S. HRG. 107–744

THE FISCAL YEAR 2003 BUDGET FOR VETERANS' PROGRAMS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

FEBRUARY 14, 2002

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FEBRUARY 14, 2002

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THE FISCAL YEAR 2003 BUDGET FOR VETERANS' PROGRAMS

THURSDAY, FEBRUARY 14, 2002

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 10:09 a.m., in room SR–418, Russell Senate Office Building, Hon. John D. Rockefeller IV (chairman of the committee) presiding.

Present: Senators Rockefeller, Jeffords, Akaka, Wellstone, Nelson, Specter, Thurmond, and Hutchison.

Chairman ROCKEFELLER. Good morning, and I apologize, as I often have to, for being a little bit late. And I welcome our witnesses to our hearing today. I look forward to working, as I always do, with Senator Specter, with Secretary Principi and with other veteran service organizations and all parties concerned to try to make some sense and do some good with the 2003 fiscal budget.

This is a process that we start today, and it is a crucial process. While other issues come up, and I think Senator Specter would agree with me, ultimately, nothing is more important than the budget. The early reviews of the administration's budget for the VA are mixed, and some have characterized it as the biggest increase in history for the VA and others as the best that can be expected during this difficult time.

In my view, we can do better, and in the process, we can be more forthcoming with veterans. And I think that is important. Regardless of how good or how bad a budget might be, it is important to be forthcoming.

I have a number of concerns that I will discuss today and work on in the weeks ahead with my colleague, Senator Specter, and my colleagues on the committee, because we always want to make the budget better. No one should object to that. For years, when we looked at the health care budget, we focused on the declining veteran population and therefore the declining demand. We are in a totally different predicament today. More veterans are turning to the VA health care system, and one can say that is a success story. But, of course, it carries with it budget consequences.

There can be little doubt that the proposed funding for medical care is below the amount needed to fund current services. The proposed shift of funding for retirement and other staff costs from OPM is cause for a great deal of uncertainty in this Senator's mind as is the proposed deductible, which is designed at its heart, to be blunt, to drive veterans away. I will be exploring these matters in some detail during the course of this and future meetings.

At the time Congress was enacting eligibility reform, I spoke about the dilemma that we would face in opening up the doors and providing a rich benefit package and how, down the road, we would have to face the music. Well, we are now facing the music. In my view, we and the administration have a choice: either own up to the demand for health care services and provide funding—my preference—or manage enrollment to cut back those who can receive services. This budget seems to choose the second path, but really does neither in the view of this Senator.

The administration has not requested additional appropriations sufficient to cover demand. That is, of course, the great game that we play in Washington, to claim that there is this big increase. And, of course, if the big increase is less than the cost of medical inflation, it is not really an increase and is in fact a decrease in terms of the veterans. So, you know, one can work that however one wants, but that is why I think being straight with veterans is important.

VA, but when I say VA, I suspect it is not really VA or Tony Principi. What I really mean is that OMB has chosen instead to artificially suppress demand. That is a fairly harsh thing to say, but I want it out there so we can talk about it. I will be exploring the rationale behind this as well as the likely impact if it were to be enacted.

I also express my concerns that there is much in this budget which is misleading. We seem to have an agreement on a certain level of funding but not a commitment to appropriate that amount. I intend to explore in detail how we can be certain that the VA will achieve the level of funding, get the money which is requested in the budget documents and what consequences will there be if we fail to actually get that money, authorizing and appropriating.

While there seems to be a lot of activity and energy at VBA these days, I am very concerned about the state of benefits adjudication. Some indicators show improvement, but there is a long way to go. So that is positive yet still raises a question. My comments are not all intended to be negative. I completely agree that veterans should not have to wait an average of 208 days for their claims to be decided. We have been discussing this issue of timeliness for my 18 years on this committee, but I want to be clear that gains in timeliness cannot come at the expense of the quality of the decisions, et cetera, that are made. I note that Admiral Cooper has stated in a couple of settings that he cannot justify a staffing increase, and I hope that the limited increase that you are requesting is sufficient to implement the VISN for VBA.

I am very concerned about the administration's proposal to shift the veterans' employment grant programs from the Department of Labor and, at the same time, convert them to competitive grant programs. I do not believe this proposal is sufficiently thought out to have already been included as a fait accompli, so to speak, in the President's budget; again, this is simply my view. While logistics are something that can be worked through, it is not clear to me that it makes sense to take employment programs away from the department, that is, Labor, that knows employment best.

So again, to my colleague, Senator Specter and my colleagues, we welcome you all here today. These are some of the things that I

will want to talk about. I look forward to trying to get the best fiscal year 2003 budget for you to be able to care for the veterans that you so badly want to care for, and I call now upon my distinguished colleague, Senator Specter.

[The prepared statement of Senator Rockefeller follows:]

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

I welcome our witnesses to today's hearing. I look forward to working with Senator Specter and the other Members, Secretary Principi, and with the veterans service organizations on this critical FY 2003 budget. Today is only one step in a process that will continue through the year.

The early reviews of the Administration's budget for VA have been mixed. Some have characterized it as the biggest increase in history for VA, others as the best that can be expected during this difficult time. In my view, we can do better and, in the process, be more forthcoming with veterans.

I have a number of concerns that I will discuss today and work on in the weeks ahead as we seek to shape the Department's budget for next year.

For years, when we looked at the health care budget, we focused on the declining veteran population and declining demand. We are in a totally different predicament today. More veterans are turning to the VA health care system, and that is a success story.

There can be little doubt that the proposed funding for medical care is below the amount needed to fund current services. The proposed shift of funding for retirement and other staff costs from OPM is cause for a great deal of uncertainty, as is the proposed deductible which is designed—at its heart—to drive veterans away. I will be exploring these matters in some detail.

At the time Congress was enacting eligibility reform, I spoke about the dilemma that we would face in opening up the doors and providing a rich benefit package and how, down the road, we would have to face the consequences. That time has arrived.

In my view, the Administration has a choice: Either own up to the demand for health care services and provide funding—my preference—or manage enrollment to cut back on those who can receive services. This budget seems to choose the second path, but really does neither.

The Administration has not requested additional appropriations sufficient to cover demand, nor was there a decision to manage enrollment last Fall. VA has chosen instead to artificially suppress demand with the new deductible. I will be exploring the rationale behind this, as well as the likely impact if it were to be enacted.

I am concerned that the VA is expecting to collect $1.5 billion in third party collections, deductibles and copayments in FY 2003. That is almost $500 million more than they expect to collect this year, and it means that they will have to average about $125 million a month in collections. This would be an incredible improvement over the $76 million a month in collections that they are averaging so far this year.

The Administration's budget also counts on new revenue generated by the proposed $1,500 deductible that all nonservice-connected veterans with incomes over $24,000 would have to pay for health care services. The purpose is obviously to keep health care enrollment open to all veterans, but the VA predicts that more than 100,000 veterans would not use VA health care services because of the new deductible. I am concerned about what will happen to these veterans. How many of them are currently using the VA system? How many are uninsured? And how many will have to turn to the already over-burdened Medicare system?

I also express my concerns up front that there is much in this budget which is misleading. What we seem to have is agreement on a certain level of funding but not a commitment to appropriate that amount. I intend to explore in detail how we can be certain that VA will achieve the level of funding which is included in the budget documents and what the consequences will be if we fail.

The Administration's proposal to include the full costs of the accrual of retirement and health care benefits in each agency's discretionary spending account is being touted to "correct a longstanding understatement of the true cost of" these programs. I realize that this is a government-wide initiative with which VA is complying. However, if the amount was previously aggregated in a central account and the budget books say the "proposal does not increase or decrease total budget outlays government wide," I don't understand how the costs were previously underestimated. Further, it has the added consequence of obscuring the actual funding pro-

vided for veterans services and creating a seeming competition among discretionary accounts for what had previously been a mandatory account.

While there seems to be a lot of activity and energy at the Veterans Benefits Administration these days, I am very concerned about the state of benefits adjudication. Some indicators show improvement, but there is a long, long way to go. I completely agree that veterans should not have to wait an average of 208 days for their claims to be decided, but I want to be clear that gains in timeliness cannot come at the expense of quality, which was already questionable.

I note that Admiral Cooper has stated in a couple of settings that he cannot justify a staffing increase. I hope that the limited increase VA is requesting is sufficient to implement the vision for the system's future. I do not believe that every problem can be solved by throwing more money at it, but the possibility of additional funding should not be foreclosed for what has been heralded as a Presidential priority.

I am also very concerned about the Administration's proposal to shift the veterans employment grant programs from the Department of Labor, and at the same time, convert them to competitive grant programs. I don't believe this proposal is sufficiently thought-out to have already been included in the President's budget. While logistics are something that can be worked through, it is not clear to me, that it makes sense to take employment programs away from the Department that knows employment best. I anticipate hearing much more on this before it can be considered.

Again, welcome to all of you here today. I look forward to our work on behalf of the nation's veterans in the weeks and months ahead, as the Committee continues in our efforts to get a good FY 2003 budget for veterans programs.

Senator SPECTER. Thank you very much, Mr. Chairman, and may I say at the outset that I believe you and I have made a good team. We have passed the gavel back and forth as chairman and ranking member, but Senator Rockefeller and I, the chairman and I, concur that partisanship has no place on veterans' issues, and I think we would also concur that there is too much partisanship on other matters.

I learned a long time ago that if you want to get something done in Washington, you have to be willing to cross party lines. With Senator Harkin on the LHHS Subcommittee of the Appropriations Committee, and with Senator Rockefeller on this committee, I think I have done that, and I think it is to the benefit of veterans. Chairman Rockefeller and I see virtually eye-to-eye in our efforts to improve services for veterans.

Let me thank Senator Thurmond for being here. Senator Thurmond created the Veterans' Committee, just as he created so many of the institutions in the U.S. Senate. Among the many colleagues who are on this committee, Senator Thurmond is here regularly, as he is on the floor of the Senate regularly voting, notwithstanding the fact that Strom celebrated his 99th birthday last December 5. We are looking forward to the 100th anniversary of his birth this December 5.

When I say others are not here, I am not being critical of them. We all have many conflicting assignments; I have to excuse myself early this morning due to another commitment, a budget hearing on the Coast Guard and homeland security. We all have so many competing assignments, so I do not mean my comment about the absence of others to be critical in any way. Everybody is hard at work, I know, as we speak.

With respect to the VA budget, I would like my full statement included in the record, Mr. Chairman, if I may. And I would like to make a couple of supplementary comments. Since 1996, the VA medical care enrollment has increased 62 percent from 2.9 million to 4.7 million patients, while funding for medical care has gone up

only 24 percent. And there is also an inflation factor which makes it even more difficult. We had a budget proposal last year which requested an added $700 million, but the Congress upped that figure, on a bipartisan basis under the leadership of Chairman Rockefeller, to add $1.1 billion to VA medical care funding. Candidly, even that has been insufficient to provide the kind of care which is necessary.

I have served on the Veterans' Committee for all of my 22 years in the Congress, and I consider it a heavy responsibility. I serve here in recognition of my father, Harry Specter, who was a veteran of World War I. He came from Russia, literally walked across Europe, with barely a ruble in his pocket. He did not know he had a round-trip ticket to France, not to Paris and the Follies, but to the Argonne Forest where he was wounded in action. During the Depression days, he received care from the Veterans Administration. He had an automobile accident; a spindle bolt broke on a defective car; crushing his right arm. And in 1937, he was cared for at the Veterans hospital in Wichita, KS. I used to ride a bicycle miles out of town to visit him there. Now, the city of Wichita has all grown up. But knowing what VA care meant to my own father, I am very concerned that VA care is adequate for veterans. We have a duty to care for veterans.

With respect to VA's proposed budget, there are a couple of opportunities, I think, for supplements, and I have discussed them with the Secretary. And let me commend you, Secretary Principi, for the outstanding job that are doing. You came to this job perhaps better prepared than any other Secretary, having been a Senate staffer. Nothing like having been a Senate staffer. It is a lofty position, loftier than Senator——

[Laughter.]

Senator SPECTER [continuing]. In many people's minds, especially in staffers' minds. [Laughter.]

But as you and I have discussed, on medical care insurance collections, a lot more can be done. You have candidly said that VA doctors are not as concerned with filling out the forms to collect insurance as they should be. And I have suggested to you that you might terminate some doctors who do not fill out the forms—fire them—because there is a lot of extra money out there that could, and should, come back to the VA. And on the Medicare subvention issue: there ought to be an allocation of Medicare funds to VA for the care of Medicare-eligible veterans. I know there is resistance to that in the House, but there ought to be a real effort to secure passage of Medicare subvention legislation.

VA has suggested that certain veterans pay a $1,500 annual deductible. I am opposed to that in the form you have articulated. You state it is going to be paid by those who can afford it, but it starts at an income level of $28,000 a year. I do not know anybody at $28,000 a year who can afford much of anything. I asked the Secretary what his salary was, and he told me $161,000. And I commented that he made more than Senators. He quickly adjusted the figure; said he was not sure. [Laughter.]

But I do know—stop blushing, Mr. Secretary. [Laughter.]

But I do know that someone who makes $28,000 a year is not in a position to pay a $1,500 annual deductable.

And the final comment I want to make relates to homeland security. I would like to see your department, Mr. Secretary, more involved. You get drugs, pharmaceutical supplies, at wholesale minus 24 percent.

Secretary PRINCIPI. As a starting point.

Senator SPECTER. As a starting point. Well, I think that you are in a good position to negotiate on those purchases, and I think that we ought to see you more deeply involved in procuring drugs to meet our homeland security needs.

Thank you very much, Mr. Chairman.

[The prepared statement of Senator Specter follows:]

PREPARED STATEMENT OF HON. ARLEN SPECTER, U.S. SENATOR FROM PENNSYLVANIA

Thank you, Mr. Chairman. I join you in welcoming our witnesses to this important hearing. And I look forward to hearing the testimony of Secretary Principi and his colleagues. Welcome, Tony.

I also look forward to hearing from the service organizations that will testify today. Of course, we are always eager to hear their views on the Administration's budget request—and on other issues that concern the organizations' members. Welcome, gentlemen. We very much value your work in preparing the "Independent Budget."

I start by commending the Administration for a proposal that very much improves on last year's budget submission. Last year, VA requested an increase of only $700 million in medical care funding. The Republican members of this Committee unanimously urged, in writing, that VA medical care funding be increased by $1.8 billion—more than double the Administration's requested increase. We did not fully prevail—but Congress did significantly improve on VA's request by adding over $1.1 billion in VA medical care funding, more than $½ billion more than the request VA submitted.

Even so, last November, the Secretary nearly ordered a moratorium on new enrollments of non-service-connected, non-poor—so-called, "Priority 7"—veterans in VA. One point needs to be emphasized now: last year, Congress needed to know how much of a medical care funding increase VA actually needed—and we did not get that information. As a result, even though Congress exceeded VA's budget request by a substantial margin, VA nearly declared a moratorium on new enrollments. Mr. Secretary, we need to know the amount of funding that you will need this year to avoid that result.

It would seem that while VA requests an additional $1.4 billion for medical care spending, it actually needs more than this. Otherwise, VA would not be up here asking that the Congress act to deter "Priority 7" enrollments by imposing a new $1,500 per year copayment obligation. You need to tell us, Mr. Secretary, what you actually need to avoid an enrollment moratorium. And you need to tell us what you actually need to avoid the imposition of arbitrary fees designed solely to scare veterans away from VA. VA should welcome the opportunity to treat veterans—even supposedly "low priority" veterans.

A further word, if I may, on VA's proposal that Congress impose new fees on veterans—fees over and above the increased drug copayments promulgated by VA last year—in order to raise money and deter "low priority" demand. VA is doing poorly—I'm told pitifully—in collecting funds due from veterans' insurance carriers. As I understand it, VA collects only one-quarter of what is owed to it. By my reckoning, VA could raise an additional $1 billion per year just by increasing collections from 25% to 50% of the amount owed. That, it seems to me, would be a low bar to clear.

So I must say, Mr. Secretary, that I will seriously consider your proposal to impose new fees on veterans. But I will insist that VA do better on collecting what is already owed to it by non-veterans—the insurance companies—before I will become very receptive to the idea of new fees on veterans.

And I will also suggest that VA advise this Committee what it will need to meet projected demand in fiscal year 2003—and that it ask for funding at that level. It seems plain to me that before we attempt to drive veterans away from VA by imposing fees—and that is what these fees are really all about . . . they are not about raising money—VA ought to try to get the level of funding that is needed to meet projected demand. That is what I expect the service organizations will propose. I will be hard pressed to oppose that suggestion. After all, that has always been my position in the past. And it has always been the position of this Committee.

Mr. Chairman, that concludes my opening remarks. I look forward to an informative hearing.

Chairman ROCKEFELLER. Thank you, Senator Specter.

Senator Thurmond?

Senator THURMOND. Welcome, Mr. Secretary.

[The prepared statement of Senator Thurmond follows:]

PREPARED STATEMENT OF HON. STROM THURMOND, U.S. SENATOR FROM SOUTH CAROLINA

Mr. Chairman: It is a pleasure to be here this morning to consider the budget requests for the Department of Veterans Affairs for fiscal year 2003. I join you and the members of the Committee in welcoming Secretary Principi and representatives of the Veterans Service Organizations.

Mr. Chairman, I support the President's budget plan for fighting terrorism, for our homeland defense, and for economic revitalization. I am pleased that among the President's priorities is his commitment to revitalize National Defense and to our Veterans. The President's Budget request allows the Administration to continue its focus on high-quality health care and timely benefits.

I look forward to working with you, other members of this Committee, and the Administration in providing our Veterans with the services and benefits they deserve.

Mr. Chairman, I thank the witnesses for appearing here today and I look forward to reviewing the testimony.

Chairman ROCKEFELLER. All right; Senator Akaka?

Senator AKAKA. Thank you very much, Mr. Chairman. I want to add my warm welcome to the witnesses from Veterans Affairs appearing before the committee this morning, particularly Secretary Principi, whom I have enjoyed working with to improve the benefits and services for our country's veterans.

I also want to welcome the witnesses from the Disabled American Veterans, Veterans of Foreign Wars, Paralyzed Veterans of America, AMVETS, and the American Legion. While, Mr. Chairman, I will not be able to stay for the duration of this hearing, please be assured that I will review today's record and work with my colleagues on the matters raised by the administration in its fiscal year 2003 budget request.

Mr. Chairman, I am concerned with the level of what I call true funding in this year's budget request. While the VA fiscal year 03 budget has been hailed as one of the best ever, the true increases in funding I feel are disappointing. While all Federal agencies have been required to shift payments for employee retirements and benefits from mandatory to discretionary funds, these shifts are being characterized as increases in funding, in the case before us for benefits and services for all veterans, when they are not increases at all.

I am also concerned with the proposal to create the $1,500 deductible for Priority 7 veterans and look forward to testimony today about this issue.

Mr. Chairman, I am pleased, however, to see continued collaboration between the VA and the Department of Defense. There are some exciting projects on the horizon that will truly meet the needs of those who serve in the defense of our great nation. Thank you, Mr. Chairman, and I will look forward to the testimony today.

Chairman ROCKEFELLER. Thank you, Senator Akaka.

Senator Jeffords?

Senator JEFFORDS. Thank you, Mr. Chairman.

First of all, I want to thank you for the excellent job that you are doing. In working with you over the years, I have full confidence you are going to be the best. And I really deeply appreciate that.

I also talked a little bit about the budget that you have fought so hard for, a budget that calls for an increase in veterans health services and veterans benefits. And I am concerned that in a climate of increasing health costs, the overall level of funding may not be sufficient to provide the services that veterans are entitled to and deserve. I would like to discuss your plans for requesting supplemental funding for the current year.

While I strongly support the President's decision to continue to provide care for Priority 7 veterans, I am concerned that the funding is insufficient to cover the actual costs incurred by VA medical centers, leaving them in a precarious position. When one takes into account the historic shortfalls in health care funding, I believe that it is critical that we fully support the system this year. I hope to pursue these issues later on.

Chairman ROCKEFELLER. Senator Jeffords has concluded his statement.

Senator JEFFORDS. Yes.

Chairman ROCKEFELLER. Senator Nelson?

Senator NELSON. Thank you, Mr. Chairman, and I apologize for being tardy. The Senate Armed Services Committee is also meeting at this very moment.

I want to begin by saying to my good friend Secretary Principi that it is good to see you, and I have enjoyed the working relationship. I look forward to learning more about the current budget proposal. I have certainly been impressed with your personal commitment and attention to the issues and the workings of your administration and your agency. I think you continue to work to maintain a high level of care and compassion for the veterans who are within your jurisdiction. And certainly, I appreciate your efforts on behalf of Nebraska's veterans.

I want to personally thank you for your work on the renovation issue in Grand Island, NE. It was critical to ensuring that a project that was not working necessarily in the right way; had been passed over but certainly now is in the right frame of renovation.

I have a question for you, though, about the proposed—which I understand today from further discussion with members of your staff that it may not be proposed; it may be a fait accompli—but integration of VISN's 13 and 14. And as we are looking at the budget today, the questions that will be raised, the comments that you are going to hear will always be about whether or not we are doing the right thing or enough of the right thing for our veterans.

We sent a letter on January 24 addressing my concerns about this. The mail being what it is in Washington today, that may or may not have gotten to you, but it may be there with the pile of letters from the rest of the Nebraska Congressional delegation raising questions about the merger of these two VISN's. My concern is whether or not, in a State like Nebraska that is geographically challenged or States like the Dakotas, where we have broad expanses of geography and few people, that we have capacity and that we have not only availability and affordability but the expecta-

tion that care is within some proximity of the location of our veterans.

And so, I was concerned with what appeared to me to be a unilateral decision made within a bureaucracy rather than brought to this body for consideration, and I have even considered a field hearing to try to go into what this means to people who have to travel the broad distances. Going to Minneapolis-St. Paul is a joyful experience—I say that even though Senator Wellstone is not here. [Laughter.]

But to go there because you have to for care, hundreds and hundreds of miles, may change your view of that travel. And so, I thought about what we could try to do to get the kind of information we need both as to budgets and as to care from the people on the ground, those who are the veterans or otherwise served. But I really do appreciate the willingness that you have had to step in to these areas, and I hope you will continue to have that kind of commitment to these line item budgets.

As one who has put budgets together in the past at the State level, I know that they are not easy. I know that you are aware as I became aware that there are faces behind these numbers. And I am looking at what we might do to put faces behind the VISN's merger that is apparently a fait accompli, and I hope it is not.

Thank you, Mr. Chairman.

Chairman ROCKEFELLER. Thank you, Senator Nelson.

Senator Hutchison, welcome.

Senator HUTCHISON. Thank you.

Thank you, Mr. Chairman, and I wish to thank each of the witnesses for being here. I just would like to say that the main part of the budget that I looked at is Gulf War illness about which we have spoken many times, and I want to thank you, Mr. Secretary, for creating the research review committee that would start looking at this. But in your budget, you have $14 million in research on military occupations and environmental exposures, which is a pretty big category. It is the right approach, because we know that environmental concerns are going to be part of the new wars that we fight. Chemical warfare is very much a hazard that our service members are going to face.

I want to ask you if part of this $14 million will go for research into the Gulf War Syndrome? Do you intend to continue the commitment to looking at the causes of 1 in 7 Gulf veterans' maladies and thus try to protect those who are in the field today and will be in the field tomorrow from the chemical warfare that we know they may face?

That is the major point that I want to clarify. Certainly, your spending level is greater, and we are pleased with that. I do have one facility in Texas that I think needs attention. The VA Hospital in Dallas certainly has a need for improvement. I relate to what Mr. Nelson says, that many of my veterans—and Texas has a huge number of veterans, as you know—have to travel for miles and miles and miles. From the Valley to San Antonio is probably the same as from Omaha to Minneapolis, and this travel is difficult. I think that, as we have closed bases, we have shut off some of the veterans' care and retiree care that had been available before.

I think we really have to make sure that our veterans' facilities are accessible and would hope that this would also be one of the priorities that you should be looking at.

So with that, I thank you for being here, and I thank you, Mr. Chairman.

Chairman ROCKEFELLER. Thank you, Senator Hutchison.

We should probably go to the 5-minute rule on all of us all around the table, and Mr. Secretary, I join others who congratulate you for your work——

Secretary PRINCIPI. Thank you, sir.

Chairman ROCKEFELLER [continuing]. And look forward to what you have to say.

STATEMENT OF HON. ANTHONY PRINCIPI, SECRETARY OF VETERANS AFFAIRS, ACCOMPANIED BY FRANCES MURPHY, M.D., ACTING UNDER SECRETARY FOR HEALTH; GUY H. McMICHAEL III, ACTING UNDER SECRETARY FOR BENEFITS; ROBIN L. HIGGINS, UNDER SECRETARY FOR MEMORIAL AFFAIRS; TIM S. McCLAIN, GENERAL COUNSEL; AND D. MARK CATLETT, ACTING ASSISTANT SECRETARY FOR MANAGEMENT

Secretary PRINCIPI. Thank you, Mr. Chairman, Senator Specter, members of the committee, it is a pleasure to be with you today.

I am accompanied by Dr. Murphy, our Acting Under Secretary of Health; Robin Higgins, our Under Secretary of Memorial Affairs; Judge Guy McMichael, our Acting Under Secretary of Benefits; Tim McClain, our General Counsel; and, of course Mark Catlett, who, many of you know, is our Chief Financial Officer.

Mr. Chairman, Senator Specter, committee members, I will be brief and try to highlight my prepared testimony so we can get on with the questions. Again, I am pleased to talk with you today about our 2003 budget request. We are requesting $58 billion for the VA for fiscal year 2003; $30.1 billion for our entitlement programs and $27.9 billion for our discretionary programs. Overall, for both discretionary and entitlement spending, this budget request represents a $6.1 billion increase over 2002 as enacted.

I know there has been some discussion: is it the largest increase in health care or not? Overall, it is a $2.7 billion increase, but to be fair and to be real and for an apples-to-apples comparison, you really have to take $793 million from that figure, because that is the accrual to cover health care costs and retirement costs for our employees. That amount is coming over from OPM to the VA. It is really not fair to include that in the increased funding requested for health care. Also, $260 million of the request would be revenues from the deductible, which leaves us with an actual increase, if you will, of $1.57 billion in medical care increase for 2003.

I am very proud and thankful to the President that we have been able to achieve this level of increase. I think it is the largest requested increase for VA health care. But as you mentioned, Mr. Chairman, and Senator Specter, VA faces a tremendous demand for health care in the years ahead and tremendous challenges in trying to accommodate all of the veterans who are coming to us for care.

We are also requesting $536 million for our capital funding program. That is our construction and our grant program. It is the largest request since fiscal year 1996. I think it will help us with the backlog of some of our construction projects and seismic deficiencies, and some of the extended care projects that we hope to get going in the future.

In our research program, we are requesting $409 million overall. This amount, coupled with the supplement from the medical care appropriation, funding from other departments of Government and from NIH, will give us an overall research budget of $1.46 billion for the VA to continue our important research in all areas focusing on veterans' illnesses, diseases and, as Senator Hutchison has said, to look at the environmental hazards of the battlefield as well.

Members of the committee, clearly VA has faced extraordinary growth in recent years. Since the enactment of eligibility reform in 1996, the number Priority 1–6's has grown 38 percent. The number of our patients treated has increased 11 percent between 2000 and 2001, and we project continuing increases in 2002. Concerning Priority 7 veterans—and I do not mean to pit Priority 7 veterans against the other six categories of veterans, but that is the way the distinction has been formulated in law—I am asked each year to make an enrollment decision with regard to Priority 7 veterans based upon resources available.

The growth in Priority 7's has been staggering: 500 percent since 1996. That was basically 3 percent of our workload. Today, it has grown to over a million, and the Priority 7 veterans represent 33 percent of our enrollees. With no change in law, that number will grow to almost 50 percent by the year 2010. That is what the projections say. The cumulative cost between 2003 and 2007 for Priority 7 veterans we estimate will be about $20 billion.

So I think patients are coming to us. I think we are the victim of our own success. I think quality in VA has never been better. Patient safety has never been better. We have opened about 600 outpatient clinics around the country in almost every community throughout the country so that veterans only have to drive about 30 minutes for primary care. And coupled with this, we have a lot of Medicare HMO's that have closed down throughout the country. There also are fluctuations in the economy where veterans have lost their health insurance. They may have taken a lower-paying job; the pay may still be above $28,000, which, as Senator Specter rightly said, is not a lot of money, but they fall into this category of Priority 7's.

So we are faced with a real dilemma of how we meet this growing demand for care. There are options. And let me be truthful about it: This budget does not provide the resouces to care for every veteran who wants to use VA—notwithstanding the fact that $1.57 billion is, in actual dollars, the largest increase ever requested—not the largest increase Congress has ever given us. Congress has given us more money than $1.57 billion, but the $1.57 billion is the largest increase requested by an administration.

But it is not enough money to take care of every veteran who wants to come to VA for care. Consider the pharmacy benefit that we have. Whether you are 100 percent service connected or nonservice connected with higher income, you get the same benefits,

from primary care all the way to nursing home care and extended care. We have a very generous benefit health care program.

So there is not enough money, notwithstanding this increase. There is another option: Medicare subvention. Senator Specter and I talked a little bit about that. That issue has been raised in the past. I think when the decision was made for eligibility reform and open enrollment and to open up all these outpatient clinics, there was an assumption that the VA was going to get outside funding, and that funding was going to come from the Medicare Trust Fund. Well, guess what happened? The outside funding never happened. Congress never passed it. President Clinton may have requested it; I am not sure, but it never occurred.

The issue of Medicare subvention is a key one, because the majority of our veterans are Medicare-eligible. They have paid into the Medicare Trust Fund. And we are working very hard with Secretary Thompson. I am working with Tom Scully and Dr. Murphy to look at coordination of benefits between VA and HHS. It just simply needs to be done. Whether it will be in the form of Medicare subvention or not, I do not know, but we need to coordinate our care.

Another option is to suspend enrollment for Category 7's. That is the option you have given me. I certainly do not want to say diminished quality is an option. I think we have worked hard; VHA has worked hard to improve the quality of VA health care. I think we need to maintain that at all costs, and I was prepared to suspend enrollment for new Priority 7's enrollees if we did not get enough money. In the 11th hour, we did get enough money. We can talk later about the supplemental. But the fact of the matter is that I thought suspending enrollment of Category 7's was something that I had to do to ensure quality and to ensure that the issue of waiting time to get an appointment at a primary care clinic did not continue to get worse, and indeed, it has been getting worse.

Another option is to change the benefit package; to consider whether Priority 7's should get the full range of benefits. But that is another tough issue. Another option is a deductible to let the higher-income non-service connected share in the cost of their care.

I guess my bottom line, Senator, is—can we get more money? I am not here to ask for more money; I am loyal to my administration, and the President has given me a good budget. But I think we all collectively have to make some tough decisions as to how we are going to meet this growing demand for care. A lot of Priority 7 veterans come to us for pharmacy medication benefits only because of our great, great program. But somehow, we have to grapple with this, and I am prepared to make the tough decisions, because I thought that without additional funding, the deductible was the best way; rather than cutting off enrollment—I cannot enact Medicare subvention or change the benefit package, so I went with the deductible as the best of the alternatives available to me to ensure that every veteran can come to the VA.

The deductible is not a standard deductible, either—and Senator Specter, again, alluded to this. I want to point out that I want the insurance companies to pay as much of that deductible as possible. Not all veterans have insurance, and Medicare is the best insur-

ance company in the Nation, and—as we discussed, we cannot get any money from Medicare, so those factors do limit our reimbursements.

But we will go to the insurance companies when we can. I think the deductible will be an incentive for veterans to tell us if they have insurance rather than having to pay it out of their own pockets. If a veteran does not have insurance, we are not going to deny care. They may only be able to pay $10 a month, and we will have a payment plan, because I do not want to deny veterans the opportunity to come to the VA for care. But somehow, we have to make ends meet. There is a disconnect between authorization and appropriation. I worked up here. We know that; we authorize, but then, sometimes, appropriation does not always follow through. And then, VA is stuck trying to balance the demands.

We are not even in compliance with the Mill bill on the number of VA nursing home beds. You have told me we must have 13,000-plus nursing home beds. We do not have them. Now, we can do that, but I am going to have to take money from some other program to pay for that. So there is a real crunch here. And I have not even talked about benefits. [Laughter.]

I will stop at that point, Mr. Chairman, members of the committee. I appreciate this opportunity, and I know we will have an opportunity to engage in this dialog a little further.

Thank you, Mr. Chairman.

[The prepared statement of Secretary Principi follows:]

PREPARED STATEMENT OF HON. ANTHONY J. PRINCIPI, SECRETARY OF VETERANS AFFAIRS

Mr. Chairman, and members of the Committee, good morning. I am pleased to be here today to discuss the President's 2003 budget proposal for the Department of Veterans Affairs (VA) and tell you about the significant progress we are making on behalf of the Nation's veterans.

Our budget reflects the largest increase ever proposed for veterans' discretionary programs. It ensures more veterans will receive high-quality health care, that we will provide more timely and accurate benefit claim determinations, and that we will maintain a dignified and respectful setting for deceased veterans. Our proposal reflects the debt of gratitude we owe to those who have served our country with honor. It also signals our enduring commitment to the men and women in uniform who today defend our freedom many miles away.

We are requesting $58 billion for veterans' benefits and services—$30.1 billion for entitlement programs and $27.9 billion for discretionary programs. This is an increase of $6.1 billion over the 2002 enacted level. Our budget increases VA's discretionary funding by $3.1 billion over the 2002 level, including medical care collections. Increases for specific programs are as follows: $2.7 billion for medical programs; $17 million for burial services; $94 million for the administration of veterans' benefits; and $64 million for capital programs and other departmental administration.

Our budget request includes $197 million for a new grant activity that replaces programs currently administered by the Department of Labor and $892 million for certain Federal retiree and health benefits as proposed by the Administration's Managerial Flexibility Act of 2001. Excluding these new activities, our budget for discretionary programs reflects an increase of $1.9 billion, or 7.8 percent over last year's funding level.

MEDICAL CARE

For Medical Care, we are requesting budgetary resources of $25 billion, including $1.5 billion in collections. This increase will provide health care for nearly 4.9 million unique patients—an increase of 156 thousand, or 3.3 percent, over the current 2002 estimate.

Mr. Chairman, I'm pleased to report that we are making substantial improvements to our billing and collection from third party insurers. In a collaborative effort with an external contractor, we have identified 24 actions that will yield significant enhancements to our ability to collect revenue. While many of these actions require time and investment, we have already begun improvements to the revenue collection process. I have directed that we begin the process of consolidating billing and collection services, and that we explore the cost and benefits of outsourcing these services. In addition, we are aggressively pursuing insurance identification by obtaining new HIPAA compliant software to facilitate exchange of medical information with non-VA entities. We are also mounting increased veteran and employee awareness and training campaigns. Further, we have developed a web-based performance metrics program that is used by central office and medical center staff to monitor and evaluate the critical steps in the revenue cycle. Following the original implementation of reasonable charges in September 1999, we have implemented two updates. Work is nearly complete on the next reasonable charges update, which we expect to publish in the Federal Register as an Interim Final Rule and implement during Spring 2002. We expect to collect over $1 billion this year with continuing increases in 2003 and beyond. We are committed to maximizing our revenue opportunities from this source.

VA has experienced unprecedented growth in the medical system workload over the past few years. The total number of patients treated increased by over 11 percent from 2000 to 2001—more than twice the prior year's rate of growth. For the first quarter of 2002, we experienced a similar growth rate when compared to the same period last year. The growth rate for Priority 7 medical care users has averaged more than 30 percent annually for the last 6 years, and they now comprise 33 percent of enrollees in the VA health care system. Based on current law, this percentage is expected to increase to 42 percent by 2010.

I am proud that an increasing number of veterans are choosing to receive their health care in the VA system. Despite this success, we have much to accomplish. Patient access to our medical facilities must be improved and this budget reaffirms our commitment to do so. Our goal is for veterans to receive non-urgent appointments for primary and specialty care in 30 days or less, while being seen within 20 minutes of their scheduled appointment. We have included an additional $159 million in our request to work toward this goal.

Mr. Chairman, I know you agree that VA's health care system should maintain timely, high quality care for service-connected and low income veterans and remain open to all veterans. To effectively manage participation in the system, we are proposing a $1,500 medical deductible for Priority 7 veterans. With no change in policy, the cost of care for Priority 7 veterans would grow from $1 billion in 2000 to over $5 billion in 2007. To assure that rising workload does not dilute the quality of care, Priority 7 veterans are being asked to pay for a greater portion of their health care than in the past. We are recommending that these veterans be assessed a deductible for their health care at a percentage of the reasonable charges up to a $1,500 annual ceiling. This is not a standard deductible that must be paid upfront and veterans' insurance may cover all charges. If all projections, funding levels, and the new deductible are realized, VA anticipates continued open enrollment to all veterans in 2003 without detriment to our traditional core patients—those with service-connected disabilities and lower incomes.

VA is working to meet the challenges in long-term care for veterans. However, we believe that a literal interpretation of P.L. 106–117, the "Veteran's Millennium Health Care and Benefits Act of 1999" will result in less than optimal solutions for increasing our long-term care capacity. The number of individual veterans who received care in VA increased from more than 3 million veterans in 1998 to more than 4 million veterans in 2001, due primarily to VA's efforts to expand access for primary care. During that same time period, efforts have been made to meet the increased demand for long-term care. Although the average daily census in VA nursing homes declined, veterans mandated under P.L. 106–117 to receive such care are being served in VA and contract community nursing homes. VA is also supporting a significantly increased census of veterans in state veterans nursing homes. At the same time, VA has been expanding care for veterans in home and community-based extended care, consistent with the mandates of P.L. 106–117. Indications we have received from veterans show that they are pleased with options providing long-term care closer to home, as well as alternatives to more traditional skilled-nursing environments. We look forward to working with Congress to pursue the best options to provide veterans with long-term care.

Our rapidly aging veteran population requires more health care services. Our request includes $817 million to address this rising demand. These funds will support our emphasis on access and service delivery, pharmaceutical support, prosthetics,

CHAMPVA for Life, and information technology. Management savings of over $316 million will partially offset resource needs. For example, I am establishing a program across the VA system that will implement "best practice" standards for dispensing and prescribing pharmaceuticals.

The 2003 budget supports our cooperative efforts with the Department of Defense (DoD) to improve federal health care delivery services. Over the past year, we have undertaken unprecedented efforts to improve cooperation and sharing in a variety of areas through a reinvigorated VA and DoD Executive Council. VA and DoD entered into a Memorandum of Understanding (MOU) in December 1999, with the objective of reducing contract duplication. The first addendum to that MOU resulted in the conversion of DoD's Pharmaceutical Distribution and Pricing Agreements (DAPAs) to reliance on VA's Federal Supply Schedule (FSS) contracts for pharmaceuticals, which was completed in December 2000. The second addendum is an agreement to convert DoD's DAPAs for medical/surgical products to reliance on VA's FSS. This effort was completed in December 2001. To address some of the remaining challenges, the Departments have identified four high-priority items for improved coordination: veteran enrollment, computerized patient records, cooperation on air transportation of patients, and facility sharing instead of construction.

MEDICAL AND PROSTHETIC RESEARCH

VA's clinical research program is funded at the highest level in history with a partnership of government, universities and the private sector. Over $1.46 billion will be invested in 2003: $409 million in direct appropriation; $401 million in support from the VA Medical Care appropriation primarily in the form of salary support for the clinical researchers; $460 million from federal organizations such as DoD and NIH; and $196 million from universities and other private institutions. This investment will allow VA to expand knowledge in areas critical to veterans' and other citizens' health care needs including schizophrenia, diabetes, further implementation of cholesterol and other guidelines, aging, renal failure treatment, and clinical drug treatment evaluations. This investment is relevant to the medical needs of the entire Nation and will enhance future quality of life.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES)

We continue our effort to transform the veterans' health care system under the Capital Asset Realignment for Enhanced Services (CARES) initiative. We are evaluating the health care services we provide, identifying the best ways to meet veterans' future medical needs, and realigning our facilities and services to meet those needs more effectively.

Mr. Chairman, this initiative is not a perfunctory exercise. The CARES process has already had a significant impact on our planning process. Last week, I announced my decision on realigning VA health care facilities in VISN 12. For example, we will shift inpatient services to a remodeled Chicago West Side Division, and maintain a Lakeside Division multi-specialty outpatient clinic in the downtown area. The Hines VA Medical Center will be renovated, including the Blind Rehabilitation and Spinal Cord Injury Centers. Sharing opportunities between the North Chicago VA Medical Center and the adjacent Naval Hospital Great Lakes will be enhanced.

CARES is critical to the future of VA health care. It will allow us to redirect funds from the maintenance and operation of facilities we no longer need to direct patient care. I am prepared to make the difficult choices necessary to ensure accessible care to more veterans in the most convenient and appropriate settings. We will complete CARES studies of our remaining health care networks within two years. Any savings that result from CARES will be put back into the community to provide higher quality care and more services to veterans. Changes will affect only the way VA delivers care—health care services will not be reduced.

MAJOR AND MINOR CONSTRUCTION PROGRAMS

For all capital programs (construction and grants) this is the largest request since 1996. Specifically for major construction, new budget authority of $194 million is requested. We are requesting funds for four seismic projects in exceptionally high-risk areas: two in Palo Alto, one in San Francisco, and one in West Los Angeles, CA. These projects involve primary care buildings and a consolidated research facility—all of which will be part of any service delivery option resulting from the CARES process. Seismic improvements will ensure veterans and their families, and VA staff, will continue to be cared for, and work in a safe environment. The 2003 Major request also addresses critical National Cemetery needs. Resources are included for new cemeteries in Pittsburgh, PA and Southern Florida and a columbaria and ceme-

tery improvements project at the Willamette National Cemetery, OR. Design funds are provided in the amount of $3.4 million for the design of new cemeteries in Detroit, MI and Sacramento, CA. We are also requesting funds to remove hazardous waste and asbestos from Department-owned buildings, perform an emergency response security study, reimburse the judgment fund, and support other construction-related activities.

To date, we have received $80 million in Major Construction funding to support the design and construction of projects that result from CARES studies. Our Major request for 2003 includes $5 million to continue efforts to realign our facilities.

New budget authority in the amount of $211 million is requested for the Minor Construction program. Particular emphasis will be placed on outpatient improvements, patient environment, and infrastructure improvements. A total of $35 million is earmarked for CARES-related design and construction needs. These funds have been proposed to allow VA to immediately implement CARES options that can be accomplished through the minor construction program (i.e., capital projects costing more than $500 thousand and a total project cost less than $4 million). In addition, $20 million is dedicated to a newly created category to fund minor seismic projects, which will allow VA to further address its seismic corrections needs.

VETERANS' BENEFITS

For the administration of veterans' benefits, we are requesting $1.2 billion and an additional 125 employees over the 2002 level. The President has promised to improve the timeliness and quality of claims processing. Last year, I established a claims processing task force to recommend changes that would improve the time it takes to process claims. The results of that task force, as well as implementation plans, have been presented to me and we have already begun to execute many of the recommendations.

I have set a goal of reaching 100 days to process compensation and pension claims by the summer of 2003. While the annual average number of days for these claims is projected to be 165 for 2003, we expect to achieve the 100-day goal by the last quarter of the year. Four months ago, we began a major effort to resolve 81,000 of the oldest Compensation and Pension claims. A key element of this effort involves a "Tiger Team" at the Cleveland Regional Office that will tackle many of these claims over an 18-month period. The team became fully operational in November 2001. Additionally, consolidation of pension benefit maintenance at three sites will allow VBA to free up employees to focus on rating compensation claims.

At the same time we are reducing the time it takes to process claims, we continue to improve the quality of claims processing. During 2003, the national accuracy rate for compensation and pension claims is projected to grow to 88 percent—a significant improvement from the 59 percent rate evidenced in 2000. This budget contains $3.5 million to support 64 additional employees dedicated to the Systematic Individual Performance Assessment (SIPA) initiative. This is an important contribution to enhance internal control mechanisms and bring accountability to the accuracy of claims processing.

This budget provides additional staff and resources to continue the development of information technology tools to support improved claims processing. Over the last several years, VBA has developed and implemented major initiatives, established cooperative ventures with other agencies, and used technology and training to address accuracy and timeliness. This budget continues to focus on initiatives in these high payoff areas. For example, this budget requests $6 million in support of the Virtual VA initiative. This effort, when complete, will replace the current intensive paper-based claims folder with electronic images and data that can be accessed and transferred through a web-based application.

Our budget also addresses the mandate to ensure that Montgomery GI Bill (MGIB) education benefits provide meaningful transition assistance and aid in the recruitment and retention of our Armed Forces. Recent legislation has improved these benefits and our priority is to deliver them as efficiently as possible. I am pleased to report that the Imaging Management System (TIMS) is now functioning in all four Regional Processing Offices. The electronic folders that result from this effort have expanded access points, improved data access, and enhanced customer satisfaction. This budget requests $6.2 million to develop and install the Education Expert System (TEES). Among other benefits, this expert system will enable us to automate a greater portion of the education claims process and expand enrollment certification. In 2003, we will continue to improve the accuracy and timeliness of education claims and improve blocked call rates.

Mr. Chairman, I would like to take this opportunity to mention one of VA's great success stories—the administration of more than 4 million insurance policies in

force. The American Customer Satisfaction Index (ASCI) and the University of Michigan conducted a study of the insurance death claims process and the satisfaction of beneficiaries who received awards. This study gave the VA's insurance program a score of 90 on a scale of 100. This is one of the highest scores ever recorded for either government or private industry. This budget provides funding to continue the Insurance Center's history of excellence. Our request includes a paperless processing initiative, which improves timeliness and quality of service while reducing the cost to policyholders.

NEW VETERANS EMPLOYMENT GRANTS PROGRAM

Veterans represent a unique and invaluable human resource for American society and the economy. Service personnel leave the military knowing they have made a vital contribution to their country. Veterans want to continue making meaningful contributions as they return to civilian life. However, in 21 states, fewer than 10 percent of veterans between the ages of 22 and 44 were placed in employment after seeking job search assistance from state service providers; during 2001, there was an average of 519,000 unemployed veterans, and in the same time period, 32 percent of unemployed veterans experienced 15 or more consecutive weeks of unemployment.

America's labor exchange market has evolved in the time since the foundation for current programs was laid. This budget proposes legislation that will allow VA to create a new competitive grant program to help veterans obtain employment. VA is working with the Department of Labor (DOL), veterans' service organizations and others to propose a veterans' employment program tailored to the needs of 21st century veterans seeking assistance in finding suitable employment. The details of the legislative proposal to implement this initiative are not yet final. If authorized by Congress, the new program will broaden our ability to assist veterans with employment and training services. Our first priority will be serving unemployed service-connected disabled veterans and those recently separated from military service. We will also help other veterans searching for employment. Our budget request for discretionary programs includes $197 million for the grant initiative.

We have the flexibility to design a program that will incorporate elements currently contained in the DOL grant program—transition assistance; disabled veterans' outreach; local veterans' employment representatives; and homeless veterans reintegration. Veterans look to the VA for education benefits, home loan assistance and, in some instances, rehabilitation and employment, medical care and compensation benefits in the transition years after leaving active duty. Later in life, many veterans may return to the VA for health care and ultimately burial benefits. Adding an enhanced employment opportunity program to the spectrum of care and services provided by VA would provide veterans with a single access point to a full continuum of benefits and services throughout their lifetime.

I know there are many questions left unanswered regarding this new program. We are in the process of finalizing our legislative proposal within the Administration and will submit it to you in the near future. At that time, we will be prepared to address your questions in greater detail.

NATIONAL CEMETERY ADMINISTRATION

The budget proposal includes $138 million to operate the National Cemetery Administration. The request preserves our commitment to maintain VA's cemeteries as National shrines, dedicated to preserving our Nation's history, nurturing patriotism, and honoring the service and sacrifice of our veterans. It provides a total of $10 million to continue renovation of gravesites, as well as clean, raise, and realign headstones and markers.

As noted earlier in my testimony, our budget request for Major Construction includes funds for the development of two new national cemeteries in the vicinity of Pittsburgh, PA and Miami, FL. Operating funds also are requested to prepare for interment operations in 2004 at these two locations and to begin interment operations at new cemeteries at Fort Sill, OK, and near Atlanta, GA.

MANAGEMENT IMPROVEMENTS

Mr. Chairman, last year I stated my commitment to reform VA's use of information technology. I am pleased to report that we have made substantial progress in this area and will continue our reform efforts. As VA moves forward with implementation of the One-VA Enterprise Architecture developed in 2001, we will manage information technology resources to account for all expenditures and ensure our scarce resources are spent in compliance with this Enterprise Architecture. A strong program is under development for Cyber Security. We are re-engineering our IT work-

force to ensure we have the proper skill sets to support our program needs. I have recently approved a comprehensive change in how we manage our IT projects to ensure they deliver high quality products, meet performance requirements, and are delivered on time and within budget.

VA is bringing enterprise-wide discipline and integration of our telecommunications capability to increase security, performance, and value. Command and control capabilities are being established to support the Department in times of emergency. Electronic government will be expanded and internet capabilities will be enhanced to improve the delivery of services and the sharing of knowledge for the benefit of the veteran. All of these efforts will focus on meeting the objectives of the President's Management Agenda.

We are pursuing other important initiatives that will promote better management practices throughout the Department. For example, I recently convened the VA Procurement Reform Task Force to examine our acquisition process and develop recommendations for improvement. The Task Force has presented 60 recommendations to accomplish several major goals that will enhance our ability to: 1) leverage purchasing power; 2) obtain comprehensive VA procurement information; 3) improve VA procurement organizational effectiveness; and 4) ensure a sufficient and talented VA acquisition workforce. Mandatory use of the Federal Supply Schedule, reorganization and elevation of the VHA logistics function to more quickly standardize medical and surgical supplies, and establishment of a National Item File are some of the more prominent recommendations being made in order to maximize savings in our medical care procurements. We are well on our way to achieving savings and increased effectiveness in VA's acquisition arena.

Finally, our 2003 request includes funds for a new Office of Operations, Security and Preparedness (OS&P). Since the tragic events of September 11, 2001, we have made substantial investments to address the Department's security and preparedness, and to meet our primary and critical emergency response missions. VA is the only pre-deployed nationwide health care system. We must be prepared for any disaster response. OS&P will play an important role in the Federal government's continuity of operations in the event of an emergency situation. The new office is formed with the specific intent of improving VA's ability to respond to any contingency with minimal disruption to services for veterans and their families. This office will coordinate all VA involvement with the Office of Homeland Security, FEMA, the Department of Health and Human Services and DoD.

Mr. Chairman, that concludes my formal remarks. Although many challenges lie ahead, I am proud of the accomplishments that have taken place over the past year. Our budget request for 2003 is a good budget for veterans and positions us for continued success. I thank you and the members of this Committee for your dedication to our Nation's veterans. I look forward to working with you. My staff and I would be pleased to answer any questions.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO ANTHONY J. PRINCIPI

HEALTH CARE

Question 1. What is the actual amount in requested appropriations for medical care and what is that as a percentage increase? How does that compare to the projected increase in medical inflation?

Answer. The FY 2003 appropriations request for medical care is $22,743,761,000, which represents a 6.6 percent increase over the FY 2002 appropriation of $21,330,078,000. This amount excludes medical collections ($1,448,874,000), the Civil Service Retirement System (CSRS) accrual ($251,515,000) and the Federal Employee Health Benefits (FEHB) accrual ($541,907,000). The Medical CPIU inflation rate for FY 2003 is projected to be 3.9 percent.

Question 2. Based on VA's best analysis, what is the amount the VA health care system would need next year to operate without any suppression of demand?

Answer. Twenty five billion, eight hundred seventy one million, three hundred four thousand dollars ($25,871,304,000), including the retirement liability, would be required in FY 2003 if the $1,500 deductible legislation is not passed. This amount includes $24,682,304,000 in appropriations and $1,189,000,000 in projected collections from the Health Services Improvement and Medical Care Collections Funds and an additional $40 million in reimbursements from the Extended Care Revolving Fund.

Question 3a. Please provide additional information on the budget and the effect on staffing. What staffing adjustments/RIFs will be required based upon the FY 2003 budget?

Answer. The FY 2003 staffing levels will decrease from 181,500 in FY 2002 to 181,331 in FY 2003, a 169 decrease in full-time equivalents due to attrition. RIFs are not anticipated and are always considered only as a last resort.

Question 3b. Will VA offer early outs/buyouts in FY 2003? What are the potential cost savings associated with these incentives?

Answer. VA has been authorized by the Office of Personnel Management (OPM) to offer early outs through September 30, 2002. We expect to ask OPM for new authority for FY 2003. Legislation authorizing current buyout authority for VA expires December 31, 2002. Legislative action would be necessary for VA to offer buyouts beyond that date.

Buyouts generally achieve immediate cost savings when used as incentives to get more highly paid employees to leave sooner than planned. Cost of the buyout, when paid early in the fiscal year, is less than the continued cost of the employee's salary.

Question 3c. Does the budget include any anticipated request to raise physician special pay?

Answer. No, the FY 2003 budget does not include any costs associated with additional increases in physician special pay. Any increases that may be proposed would be paid from existing resources. The Administration is getting ready to propose legislation (for the short term) to address physician pay. This legislation will allow VA to save money from contracts and use it for physician pay.

Question 4a. As you know, I remain concerned about the CARES process, and its effect on critical construction needs within VA's health care system. Please provide the list of medical facilities, and describe what constitutes a facility.

Answer: Attached is a list of medical facilities, "VA Facilities by Type." The following glossary, extracted from the end of year report for FY 2001 VA Site Tracking (VAST) describes each type of facility. These definitions were set by the VHA Policy Board in December 1998 and are the basis for defining the category and the additional service types for each VHA service site. These definitions cover sites generally owned by the VA with the exception of leased and contracted CBOCs.

VA HOSPITAL—An institution owned, staffed, and operated by VA that provides inpatient services. Each division of an integrated medical center is counted as a separate hospital.

VA NURSING HOME—A Nursing Home Care Unit (NHCU) provides care to individuals who are not in need of hospital care, but who require nursing care and related medical or psychosocial services in an institutional setting. A VA NHCU is designed to care for patients who require a comprehensive care management system coordinated by an interdisciplinary team. Services provided include nursing, medical, rehabilitative, recreational, dietetic, psychosocial, pharmaceutical, radiological, laboratory, dental and spiritual.

VA DOMICILIARY—A VA facility that provides comprehensive health and social services to eligible veterans who are ambulatory and do not require the level of care provided in nursing homes.

VA Outpatient Clinics:

HOSPITAL-BASED OUTPATIENT CLINIC (HBOC)—A clinic located within a hospital that provides outpatient clinic functions.

INDEPENDENT OUTPATIENT CLINIC (IOC)—A full-time, self-contained, freestanding, ambulatory care clinic that provides primary and specialty health care services in an outpatient setting. IOCs have no management, program, or fiscal relationship to a VA hospital.

MOBILE OUTPATIENT CLINIC (MOC)—A specially equipped van with multiple scheduled stops that provides outpatient care. A mobile clinic is under the jurisdiction of a parent medical facility.

COMMUNITY-BASED OUTPATIENT CLINIC (CBOC)—A VA operated, VA funded, or VA reimbursed health care facility or site geographically distinct or separate from a parent medical facility. This term encompasses all types of VA outpatient clinics, except hospital-based, independent, and mobile clinics. Satellite, community-based, and outreach clinics have been redefined as community-based outpatient clinics.

VA OWNED—A CBOC owned and staffed by the VA.

LEASED—A CBOC where the space is leased (contracted), but is staffed by the VA.

CONTRACTED—A CBOC where the space and staff are not VA. This is typically an HMO type provider where multiple sites can be associated with a single station identifier.

NOT OPERATIONAL—A CBOC that has been approved by Congress, but has not yet become operational. CBOCs opened after March 1995 require Congressional approval.

VETERANS CENTER—A center, managed by VHA's Readjustment Counseling Service, that provides professional readjustment counseling, community education, outreach to special populations, brokering of services with community agencies, and access to links between the veteran and the VA.

ATTACHMENT—VA FACILITIES BY TYPE (as of December 2001)

EMPLOYEE EDUCATION CENTERS (19)

Alabama: Birmingham; Tuskegee
Arizona: Prescott
Arkansas: North Little Rock
California: Long Beach
District of Columbia: Washington
Georgia: Dublin
Idaho: Boise
Maine: Togus
Maryland: Perry Point
Minnesota: Minneapolis
Missouri: St. Louis (Jefferson Barracks Division)
Nebraska: Lincoln
New York: Northport
North Carolina: Durham
Ohio: Cleveland (Brecksville Div.)
Pennsylvania: Erie
South Dakota: Fort Meade
Utah: Salt Lake City

CANTEEN SERVICE CENTRAL OFFICE AND FINANCE CENTER (1)

Missouri: St. Louis

CANTEEN SERVICE FIELD OFFICES (3)

California (Western): Sepulveda
Maryland (Eastern): Ft. Howard
Missouri (Central): St. Louis (Jefferson Barracks)

GERIATRIC RESEARCH, EDUCATION, AND CLINICAL CENTERS (21)

Alabama/Georgia: Birmingham/Atlanta
Arkansas: Little Rock
California: Palo Alto; Sepulveda; West Los Angeles
Florida: Gainesville; Miami
Maryland: Baltimore
Massachusetts: Boston
Michigan: Ann Arbor
Minnesota: Minneapolis
Missouri: St. Louis (John J. Cochran Division)
New York: Bronx/New York Harbor
North Carolina: Durham
Ohio: Cleveland
Pennsylvania: Pittsburgh
Tennessee: Murfreesboro/Nashville
Texas: San Antonio
Utah: Salt Lake City
Washington: Seattle (Puget Sound HCS)
Wisconsin: Madison

SERVICE AND DISTRIBUTION CENTER (1)

Illinois: Hines

CENTRAL OFFICE (1)

District of Columbia: Washington

FINANCE CENTERS (2)

Texas: Austin
Illinois: Hines

RECORDS MANAGEMENT CENTER (1)

Missouri: St. Louis

AUTOMATION CENTER (1)

Texas: Austin

NATIONAL ACQUISITION CENTER (1)

Illinois: Hines

SYSTEMS DEVELOPMENT CENTERS (2)

Illinois: Hines
Texas: Austin

DENVER DISTRIBUTION CENTER (1)

Colorado: Denver

CENTRAL DENTAL LABORATORIES (2)

District of Columbia: Washington
Texas: Dallas

PREVENTIVE DENTAL SUPPORT CENTER (1)

Texas: Houston

MIAMI DEVELOPMENT CENTER FOR DENTAL OPERATIONS (1)

Florida: Miami

PROSTHETIC AND SENSORY AIDS RESTORATION CLINICS (6)

California: West Los Angeles
Georgia: Decatur (Atlanta)
Missouri: St. Louis (Jefferson Barracks Division)
New York: New York
Ohio: Cleveland
Oregon: Portland

LAW ENFORCEMENT TRAINING CENTER (1)

Arkansas: Little Rock

HEALTH ADMINISTRATION MANAGEMENT CENTER (1)

Colorado: Denver

ORTHOTIC/PROSTHETIC LABORATORIES (59)

Alabama: Montgomery
Arizona: Tucson
Arkansas: Little Rock
California: Long Beach; Palo Alto; San Diego; San Francisco; Sepulveda; West Los Angeles
Colorado: Denver
Florida: Bay Pines; Gainesville; Miami; Tampa; West Palm Beach
Georgia: Decatur (Atlanta)
Illinois: Chicago (Westside); Hines
Indiana: Indianapolis
Kansas: Wichita
Kentucky: Louisville
Louisiana: New Orleans
Maine: Togus
Maryland: Ft. Howard
Massachusetts: Boston; Brockton (West Roxbury)
Michigan: Detroit
Minnesota: Minneapolis

Missouri: Kansas City; St. Louis
New Jersey: East Orange
New Mexico: Albuquerque
New York: Albany; Bronx; Brooklyn; Buffalo; Castle Point; New York; Northport
Ohio: Cincinnati; Cleveland; Dayton
Oklahoma: Oklahoma City
Oregon: Portland
Pennsylvania: Pittsburgh (UD); Wilkes Barre
Puerto Rico: San Juan
South Carolina: Columbia
Tennessee: Memphis; Nashville
Texas: Dallas; Houston; San Antonio; Temple
Virginia: Hampton; Richmond
Washington: Seattle
West Virginia: Martinsburg
Wisconsin: Milwaukee

HEALTH ELIGIBILITY CENTER (1)

Georgia: Atlanta

DOMICILIARIES (43)

Alabama: Tuskegee
Alaska: Anchorage
Arizona: Prescott
Arkansas: North Little Rock
California: Palo Alto-Menlo Park; West Los Angeles
Florida: Bay Pines; Orlando
Georgia: Augusta; Dublin
Illinois: N. Chicago
Iowa: Des Moines; Knoxville
Kansas: Leavenworth
Maryland: Perry Point
Massachusetts: Bedford; Brockton
Minnesota: St. Cloud
Mississippi: Biloxi
Missouri: St. Louis
New Jersey: Lyons
New York: Bath; Canandaigua; Montrose; St. Albans
Ohio: Chilicothe; Cincinnati; Cleveland; Dayton
Oregon: Portland; White City
Pennsylvania: Butler; Coatesville; Pittsburgh
South Dakota: Hot Springs
Tennessee: Mountain Home
Texas: Bonham; Dallas; Temple
Virginia: Hampton
Washington: Tacoma
West Virginia: Martinsburg
Wisconsin: Milwaukee

VA HOSPITALS (172)

Alabama: Birmingham; Montgomery; Tuscaloosa; Tuskegee
Arizona: Northern Arizona HCS Phoenix; Southern Arizona HCS
Arkansas: Central Arkansas Veterans HCS LR; Central Arkansas Veterans HCS NLR; Fayetteville
California: Fresno; Livermore; Loma Linda; Long Beach HCS; Palo Alto (Menlo Park); Palo Alto (Palo Alto); San Diego HCS; San Francisco; West Los Angeles (Brentwood); West Los Angeles (Wadsworth)
Colorado: Denver; Fort Lyon; Grand Junction
Connecticut: Newington; West Haven
Delaware: Wilmington
District of Columbia: Washington
Florida: Bay Pines; Lake City; Miami; North Florida/South Georgia HCS; Tampa; West Palm Beach
Georgia: Augusta; Decatur; Dublin; Lenwood (Uptown)
Idaho: Boise
Illinois: Chicago (Westside); Chicago (Lakeside Division); Danville; Hines; Marion; North Chicago

Indiana: Indianapolis (Cold Springs); Indianapolis (West 10th Street); North Indiana HCS–Ft. Wayne; North Indiana–Marion
Iowa: Des Moines; Iowa City—Central Plains HCS; Knoxville
Kansas: Leavenworth; Topeka-Colmery-O'Neil; Wichita
Kentucky: Lexington (Cooper Drive); Lexington (Leestown); Louisville
Louisiana: Alexandria; New Orleans; Shreveport (Overton Brooks)
Maine: Togus
Maryland: Baltimore; Fort Howard; Perry Point
Massachusetts: Bedford; Boston VAMC; Brockton Division; Brockton (West Roxbury); Northampton
Michigan: Ann Arbor HCS; Battle Creek; Detroit (John D. Dingell); Iron Mountain; Saginaw
Minnesota: Minneapolis; St. Cloud
Mississippi: Biloxi (Gulfport); Gulf Coast HCS; Jackson (G. V. (Sonny) Montgomery)
Missouri: Columbia; Kansas City; Poplar Bluff; St. Louis (Jefferson Barracks); St. Louis (John J. Cochran)
Montana: Fort Harrison; Miles City
Nebraska: Grand Island; Lincoln; Omaha
Nevada: Sierra Nevada HCS (Reno); Southern Nevada HCS (Las Vegas)
New Hampshire: Manchester
New Jersey: Lyons; East Orange
New Mexico: New Mexico HCS
New York: Albany; Bath; Bronx; Brooklyn (Poly PI.)—New York Harbor HCS; Canandaigua; Castle Point; Hudson Valley HCS; New York Harbor HCS; New York Harbor HCS (St. Albans Campus); Northport; Saracuse; Upstate New York HCS (Buffalo); Upstate New York HCS (Batavia)
North Carolina: Asheville—Oteen; Durham; Fayetteville; Salisbury—W. G. (Bill) Hefner
North Dakota: Fargo
Ohio: Chilicothe; Cincinnati; Cleveland (Brecksville); Cleveland (Wade Park); Dayton
Oklahoma: Muskogee; Oklahoma City
Oregon: Portland; Roseburg (HCS)
Pennsylvania: Altoona—James E. Van Zandt; Butler; Coatesville; Erie; Lebanon; Philadelphia; Pittsburgh HCS—(Aspinwall); Pittsburgh HCS—(Highland Drive); Pittsburgh HCS—(University Drive); Wilkes-Barre
Rhode Island: Providence
South Carolina: Charleston; Columbia
South Dakota: Fort Meade; Hot Springs; Sioux Falls
Tennessee: Memphis; Middle Tennessee HCS; Middle (Nashville); Tennessee HCS—(Murfreesboro); Mountain Home
Texas: Amarillo HCS; Bonham; Dallas; Houston; Kerrville; Marlin; San Antonio; Temple; Waco; West Texas HCS
Utah: Salt Lake City HCS
Vermont: White River Junction
Virginia: Hampton; Richmond; Salem
Washington: American Lake (Tacoma); Seattle; Spokane; Vancouver; Walla Walla
West Virginia: Beckley; Clarksburg; Huntington; Martinsburg
Wisconsin: Madison; Milwaukee; Tomah
Wyoming: Cheyenne; Sheridan

NURSING HOME UNITS (137)

Alabama: Tuscaloosa; Tuskegee
Arizona: Phoenix; Prescott; Tucson
Arkansas: Little Rock
California: Fresno; Livermore; Loma Linda; Long Beach; Martinez; Palo Alto; San Diego; San Francisco; Sepulveda; Greater Los Angeles
Colorado: Denver; Southern Colorado HCS; Grand Junction
Connecticut: West Haven
Delaware: Wilmington
District of Columbia: Washington
Florida: Bay Pines; Gainesville; Lake City; Miami; Orlando; Tampa; West Palm Beach
Georgia: Augusta; Decatur; Dublin; Lenwood
Hawaii: Honolulu
Idaho: Boise

Illinois: Danville; Hines; Marion; North Chicago
Indiana: Fort Wayne; Indianapolis; Marion
Iowa: Knoxville
Kansas: Leavenworth; Topeka; Wichita
Kentucky: Lexington
Louisiana: Alexandria; New Orleans
Maine: Togus
Maryland: Baltimore; Loch Raven; Perry Point
Massachusetts: Bedford; Brockton; Northampton
Michigan: Ann Arbor; Battle Creek; Detroit; Iron Mountain; Saginaw
Minnesota: Minneapolis; St. Cloud
Mississippi: Biloxi; Jackson
Missouri: Columbia; Poplar Bluff; St. Louis
Montana: Fort Harrison; Miles City
Nebraska: Grand Island
Nevada: Reno
New Hampshire: Manchester
New Jersey: East Orange; Lyons
New Mexico: Albuquerque
New York: Albany; Batavia; Bath; Bronx; Buffalo; Canandaigua; Castle Point; Montrose; Northport; St. Albans; Syracuse
North Carolina: Asheville; Durham; Fayetteville; Salisbury
North Dakota: Fargo
Ohio: Chilicothe; Cincinnati; Cleveland; Dayton
Oklahoma: Oklahoma City
Oregon: Roseburg
Pennsylvania: Altoona; Butler; Coatesville; Erie; Lebanon; Philadelphia; Pittsburgh (Aspinwall); Pittsburgh (HD); Wilkes Barre
Puerto Rico: San Juan
South Carolina: Columbia; Charleston
South Dakota: Fort Meade; Sioux Falls
Tennessee: Mountain Home; Murfreesboro
Texas: Amarillo; Big Spring; Bonham; Dallas; Houston; Kerrville; Marlin; San Antonio; Temple
Virginia: Hampton; Richmond; Salem
Washington: Seattle; Spokane; Tacoma; Vancouver; Walla Walla
West Virginia: Beckley; Martinsburg
Wisconsin: Milwaukee; Tomah
Wyoming: Cheyenne; Sheridan

VET CENTERS (206)

Alabama: Birmingham; Mobile
Alaska: Anchorage; Fairbanks; Soldotna; Wasilla
Arizona: Phoenix; Prescott; Tucson
Arkansas: North Little Rock
California: Anaheim; Capitola; Chico; Commerce; Concord; Culver City; Eureka; Fresno; Gardena; North Bay; Oakland; Peninsula (Redwood City); Riverside; Rohnert Park; Sacramento; San Bemadino; San San Diego; San Francisco; San Jose; Santa Barbara; Sepulveda; Vista
Colorado: Boulder; Colorado Springs; Denver
Connecticut: Hartford; New Haven; Norwich
Delaware: Wilmington
District of Columbia: Washington, DC
Florida: Fort Lauderdale; Jacksonville; Lake Worth; Miami; Orlando; Pensacola; Sarasota; St. Petersburg; Tallahassee; Tampa
Georgia: Atlanta; Savannah
Guam: Agana
Hawaii: Hilo; Honolulu; Kailua-Kona; Lihue; Wailuku
Idaho: Boise; Pocatello
Illinois: Chicago; Chicago Heights; East St. Louis; Evanston; Moline; Oak Park; Peoria; Springfield
Indiana: Evansville; Fort Wayne; Highland (Gary); Indianapolis
Iowa: Cedar Rapids; Des Moines; Sioux City
Kansas: Wichita
Kentucky: Lexington; Louisville
Louisiana: New Orleans; Shreveport
Maine: Bangor; Caribou; Lewiston; Portland; Sanford

Maryland: Baltimore; Bel Air; Silver Spring
Massachusetts: Boston; Brockton; Lowell; New Bedford; Springfield; Worcester
Michigan: Detroit; Grand Rapids; Lincoln Park (Detroit)
Minnesota: Duluth; St. Paul
Mississippi: Biloxi; Jackson
Missouri: Kansas City; St. Louis
Montana: Billings; Missoula
Nebraska: Lincoln; Omaha
Nevada: Las Vegas; Reno
New Hampshire: Manchester
New Jersey: Jersey City; Newark; Trenton; Ventnor
New Mexico: Albuquerque; Farmington; Sante Fe
New York: Albany; Babylon (Long Island); Bronx; Brooklyn; Buffalo; Harlem; Manhattan; Rochester; Staten Island; Syracuse; White Plains; Woodhaven
North Carolina: Charlotte; Fayetteville; Greensboro; Greenville; Raleigh
North Dakota: Fargo; Minot
Ohio: Cincinnati; Cleveland; Columbus; Dayton; Parma (Cleveland)
Oklahoma: Oklahoma City; Tulsa
Oregon: Eugene; Grants Pass; Portland; Salem
Pennsylvania: Erie; Harrisburg; McKeesport; Philadelphia (2); Pittsburgh; Scranton; Williamsport
Rhode Island: Cranston (Providence)
South Carolina: Columbia; Greenville; North Charleston
South Dakota: Rapid City; Sioux Falls
Tennessee: Chattanooga; Johnson City; Knoxville; Memphis
Texas: Amarillo; Austin; Corpus Christi; Dallas; El Paso; Fort Worth; Houston (2); Laredo; Lubbock; McAllen; Midland; San Antonio
Utah: Provo; Salt Lake City
Vermont: South Burlington; White River Junction
Virginia: Alexandria; Norfolk; Richmond; Roanoke
Washington: Bellingham; Seattle; Spokane; Tacoma; Yakama Valley
West Virginia: Beckley; Charleston; Huntington; Martinsburg; Morgantown; Princeton; Wheeling
Wisconsin: Madison; Milwaukee
Wyoming: Casper; Cheyenne
Puerto Rico: Arecibo; Ponce; Rio Piedras
Virgin Islands: St. Coix; St. Thomas

VA OUTPATIENT CLINICS (684) (EXCLUDES CLINICS LOCATED AT VA MEDICAL CENTERS (AS OF DECEMBER 31, 2001))

Alabama: Anniston; Decatur; Dothan; Florence; Gadsden; Huntsville; Jasper; Mobile
Alaska: Fairbanks; Kenai
Arizona: Bellemont; Casa Grande; Green Valley; Kingman; Lake Havasu; Mesa; Safford; Show Low; Sierra Vista; Sun City; Yuma
Arkansas: Eldorado; Ft. Smith; Harrison; Hot Springs; Jonesboro; Mountain Home; Paragould
California: Anaheim; Antelope Valley; Bakersfield; Cabrillo; Chico; Chula Vista; Corona; Culver City; East Los Angeles Clinic; El Centro; Eureka; Fairfield; Gardena; Lompoc; Los Angeles; Martinez; McClellan; Merced; Mission Valley; Modesto; Monterey; Oakland;*** Palm Desert; Palo Alto HCS (Capitola); Port Hueneme; Redding; San Francisco; San Jose; San Luis Obispo; Santa Ana; Santa Barbara; Santa Rosa; Sepulveda; Sierra Foothills; Stockton; Sun City; Travis;** Tulare; Ukiah; Vallejo/Mare Island; Victorville; Vista
Colorado: Alamosa; Aurora; Colorado Springs; Ft. Collins (LaPorte); Greeley; La Junta; Lakewood; Lamar County; Montrose; Pueblo; Southern Colorado HCS
Connecticut: New London;* Newington Campus; Norwich Screening Clinic; Stamford;* Waterbury;* Windham;* Winsted
Delaware: Dover AFB; Millsboro
District of Columbia: Southeast Washington
Florida: Avon Park; Brooksville; Clearwater; Daytona Beach; Delray Beach; Fort Pierce; Ft. Myers; Homestead; Inverness; Jacksonville; Key West; Kissimmee; Lakeland; Leesburg; Manatee; Miami; Naples; Oakland Park; Ocala; Okeechobee; Orlando; Panama City; Pembrook Pines; Pensacola; Port Charlotte; Port Richey; Sanford; Sarasota; South St. Petersburg; St. Augustine; Stuart; Tallahassee; Vero Beach; Viera; Zephyrhills

Georgia: Albany; Atlanta (Midtown); Cobb County; Columbus; Lawrenceville; Macon; NE Georgia/Oakwood; Savannah; Valdosta

Guam: Agana Heights

Hawaii: Hilo; Kailua-Kona; Lihue; Wailuku

Idaho: Lewiston; Ontario; Pocatello; Twin Falls

Illinois: Aurora; Bellville; Chicago Heights; Decatur; Effingham; Elgin; Evanston; Galesburg; Joliet; LaSalle; Manteno; McHenry; Mt. Vernon; Oak Lawn; Oak Park; Peoria; Quincy; Rockford; Springfield; Woodlawn

Indiana: Bloomington; Crown Point; Evansville; Lafayette; Muncie; New Albany; Richmond; South Bend; Terre Haute

Iowa: Bettendorf; Dubuque; Ft. Dodge; Marshalltown; Mason City; Sioux City; Waterloo

Kansas: Abilene; Chanute; Dodge City; Emporia; Fort Riley; Fort Scott; Garnett; Hays; Holton; Junction City; Lawrence; Liberal; Paola; Parsons; Seneca; Russell; Wyandotte County

Kentucky: Bellvue; Bowling Green; Fort Knox; Hopkinsville; Louisville; Paducah; Prestonburg; Somerset; Whitesburg

Louisiana: Baton Rouge; Jennings; Lafayette Parish; Monroe

Maine: Aroostook County; Bangor; Calais; Machias; Portland; Rumford; Saco

Maryland: Cambridge; Cumberland; Glen Burnie; Hagerstown; Landover; Loch Raven; Southern Maryland

Massachusetts: Causeway Clinic; Dorchester; Edgartown; Framingham;* Greenfield; Haverhill; Hyannis;** Lowell; Nantucket; New Bedford;** North Shore; Pittsfield;**** Quincy; Springfield (2); Winchendon; Worcester

Michigan: Benton Harbor; Flint; Gaylord; Grand Rapids; Hancock; Ironwood; Jackson; Lansing; Marquette; Menominee; Muskegon; Oscoda; Pontiac; Sault Ste. Marie; Traverse City; Yale

Minnesota: Brainerd; Fergus Fall; Hibbing (4); Mankato (10); Maplewood (St. Paul)

Mississippi: Byhalia; Greenville; Hattiesburg; Meridian; Smithville (2)

Missouri: Belton; Cape Girardeau; Ft. Leonard Wood; Gene Taylor; Kirksville; Lake of the Ozarks; Nevada; St. Charles County; St. Joseph; St. Louis CBOC; West Plains

Montana: Anaconda; Billings; Bozeman; Glasgow; Great Falls; Lame Deer; Miles City; Missoula; Northeast (Sidney); Whitefish

Nebraska: Alliance; Gering; Grand Island; Lincoln; Norfolk; North Platte; Rushville; Sidney

Nevada: Carson City; Ely; Henderson; Las Vegas Homeless; Pahrump

New Hampshire: Conway; Portsmouth; Tilton; Wolfeboro

New Jersey: Brick; Cape May; Elizabeth; Ft. Dix; Hackensack; Jersey City; Morristown; Newark; New Brunswick; State Soliders Home; Trenton; Ventnor

New Mexico: Alamogordo; Artesia; Clovis; Espanola (6); Farmington; Gallup; Hobbs; Las Cruces; Las Vegas (6); Raton; Santa Rosa; Sante Fe County; Silver City; Truth or Consequences

New York: Auburn; Batavia; Binghamton Community; Buffalo; Brooklyn (Bedford); Brooklyn (Sister Boman); Carmel (Putnam County); Catskill; Chapel St; Clifton Park; Courtland; Dunkirk; East Buffalo; Elizabethtown; Elmira; Far Rockaway; Fonda; Geneseo; Geneva; Glen Falls (2); Harlem; Harlem Homeless; Harris; Islip; Ithaca; Jamestown; Kingston; Lackwanna; Lindenhurst; Lockport; Lynbrook; Lyons; Malone; Massena; Middletown; Mt. Morris; Mt. Sinai; New City; New York SOC; Olean; Oswego; Patchoque; Plainview; Plattsburg; Port Jervis; Poughkeepsie; Queens; Riverhead; Rochester; Rome; Sayville; Schenectady; Sidney; Soho; Sonyea; South Bronx; Staten Island; Troy; Watertown; Wellsville; White Plains; Yonkers

North Carolina: Charlotte; Greenville; Jacksonville (2); Raleigh; Wilmington; Winston-Salem

North Dakota: Bismarck; Grafton; Minot

Ohio: Akron; Ashtabula County; Athens; Canton; East Liverpool; Grove City; Lancaster; Lima; Lorain; Mansfield; Marietta; McCafferty; Middletown; Painesville; Portsmouth; Sandusky; Springfield; St. Clairsville; Toledo; Warren; Youngstown; Zanesville

Oklahoma: Ardmore; Clinton; Konawa; Lawton; McAlister; Ponca City; Tulsa

Oregon: Bandon; Bend; Brookings; Eugene; Klamath Falls; Salem; White City

Pennsylvania: Aliquippa; Allentown; Berwick; Camp Hill;# Clarion County; Coatesville; Crawford County;** Dubois (Clearfield); Good Samaritan;### Greensburg; Health Place; Jamison Health Center; Johnstown; Kittanning; Lancaster; Mckean County Media; Philadelphia; Reading; Sayre; Spring City; State College; Tobyhanna; Washington Co.; Williamsport; York

Puerto Rico: Arecibo; Mayaguez; Ponce

Rhode Island: Middletown
South Carolina: Beaufort; Florence; Greenville; Myrtle Beach; Orangeburg Co.
South Dakota: Aberdeen; Eagle Butte; Kyle; McLaughlin; Pierre; Pine Ridge; Rapid City; Rosebud; Winner
Tennessee: Chattanooga; Clarksville; Cookeville; Dover; Knoxville; Mountain City; Rogersville; Savannah; Tullahoma
Texas: Abilene; Alice; Austin Satellite; Beaumont; Beeville; Bonham Care; Network ## (20); Brownsville; Brownwood; Camp-Fannin; Cedar Park; Childress; Cleburne ## (3); College Station (Bryan); Corpus Christi Satellite; Dallas County; ## Decatur Area ## (3); Del Rio; Denton Area ##; Eagle Pass; Eastland Area ## (3); Ft. Stockton; Fort Worth Satellite; Greenville Area ## (4); Kingsville; Laredo; Longview; Lubbock; Lufkin; Marlin VAMC; McAllen Satellite; Odessa; Palestine; San Angelo; San Antonio (5); San Marcos; Sanquin; South Bexar County; Stamford; Stratford; Tarrant County ## (4); Frank M. Tejeda; Texarkana; Uvalde; Victoria; Wichita Falls
Utah: Ogden; Orem; Roosevelt; Saint George
Vermont: Bennington; Burlington; VICC—Newport; VICC—St. Johnsbury; Wilder
Virgin Islands: St. Croix; St. Thomas
Virginia: Alexandria; Covington; Danville (Riverside Drive) (2); Danville (A.L. Post 325); Harrisonburg; Hillsville; Lynchburg; Marion; Martinsville; Norton (2); Pulaski; St Charles (8); Stephens City; Stuarts Draft; Tazewell
Washington: Bremerton; King County (2); Longview; Richland; Vancouver; Yakima
West Virginia: Charleston; Franklin; Gassaway; Logan County; Petersburg; Tucker County; Wood County
Wisconsin: Appleton; Baraboo; Beaver Dam; Chippewa Falls; Cleveland; Eau Claire; Edgerton; La Crosse; Loyal; Rhinelander; Superior; Union Grove; Wausau
Wyoming: Casper; Gillette; Green River; Newcastle; Powell; Riverton

* VA Primary Care Center
** Primary Care Clinic
*** Substance Abuse Treatment Clinic
**** Veterans Community Care Center
# Outpatient Clinic
Primary Care Network
Regional Medical Center

INDEPENDENT (4)

Alaska: Alaska HCS
Ohio: Columbus
Manila: Passay City
Texas: El Paso HCS

MOBILE CLINIC (8)

District of Columbia: Washington
Maryland: Baltimore
Missouri: Poplar Bluff
North Carolina: Fayetteville
Pennsylvania: Northeastern Pennsylvania
Washington: Spokane
West Virginia: Martinsburg
Wisconsin: Milwaukee

MEDICAL AND REGIONAL OFFICE CENTERS (11)

Alaska: Anchorage
Delaware: Wilmington
Hawaii: Honolulu
Kansas: Wichita
Maine: Togus
Montana: Fort Harrison
North Dakota: Fargo
South Dakota: Sioux Falls
Vermont: White River Junction
Wyoming: Cheyene
Manila: * Pasay City
* Manila is classified as an Independent Outpatient Clinic not a Medical Center

Question 4b. What were the costs of the Phase I CARES study?

Answer. Current payments to the Booz-Allen and Hamilton CARES contractor, actuary, and facility condition assessment contractors are $4.8 million.

Question 4c. Will you be doing a Phase II and Phase III CARES study and if so, what is the schedule and funding?

Answer. VA is exploring performing all remaining CARES studies simultaneously in Phase II. The initial target date for completing the remaining studies is calendar year 2003. During Phase I, VA staff played a key role in the CARES process; as a result consideration is being given to VA staff performing the majority of the work in future studies. Until the overall process is finalized, cost information for the future studies will not be available.

Question 5a. In FY 2001, VHA collected $771 million in copayments and third party collections. In FY 2003, VHA has estimated that it will collect $1.5 billion. Part of this increase will be based upon new revenues generated by raising the prescription copayment from $2 to $7 and part of the increase will be due to anticipated improved collection processes. With that in mind: VA is estimating $1.5 billion in collections for FY 2003, doubling the amount from the FY 2001 level of $771 million. What is the primary reason for this increase, and can we realistically anticipate this level of collections?

Answer. The primary reasons for the increase from $771 million in FY 2001 to the projected $1.5 billion in FY 2003 are as follows:

$364 million for the $5 (from $2 to $7) increase in medication copayment;

$260 million for proposed legislative initiative for the $1,500 deductible;

$40 million for the long term care copayment;

Improvements derived from the Revenue Improvement Plan; and

Four broad-sweeping activities (Electronic Data Interchange (EDI), Centralization & Consolidation, Outsourcing & Contracting Medicare remittance advice for a project)—all of which will have a profound impact upon the MCCF program to help increase collections.

Question 5b. Please provide all background assumptions, spreadsheets and analyses used in the determination that 121,000 veterans would no longer use VA health care services and that an estimated annual savings of $885 million in reduced workload will be realized due to the proposed annual $1,500 deductible to Priority 7 veterans. Please also include how many of the 121,000 are current users and how many are potential enrollees.

Answer. The attachment, "Background on VA's $1,500 Deductible Proposal for Priority 7 Veterans", provides the background assumptions and details of this proposal.

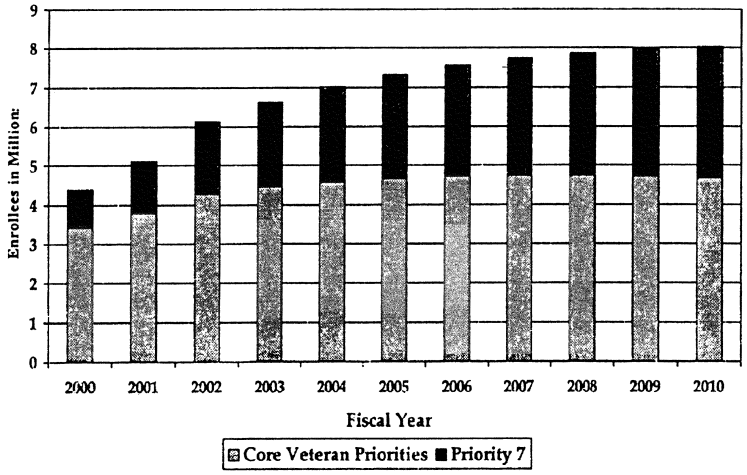
ATTACHMENT—BACKGROUND ON VA'S $1,500 DEDUCTIBLE PROPOSAL FOR PRIORITY 7 PATIENTS

VA's estimate of the financial and programmatic impact of the $1,500 deductible upon Priority 7 veterans was based upon the Milliman USA, Inc. actuarial estimates for projections of enrollees and resources that were used as the foundation of the FY 2002 enrollment decision. The actuarial estimates were based upon FY 2000 actual experience and did not reflect increased utilization by Priority 7 veterans seen in FY 2001. The actuarial estimates were first available in late summer of 2001.

Future Year Projections

This deductible policy would not have been proposed if the growth in Priority 7 veterans was estimated to be a one or two year anomaly. As the chart below shows, the Priority 7 workload is estimated to continue to rise through 2010.

PROJECTED ENROLLMENT BY PATIENT PRIORITY



VA's primary reason for proposing a significant policy change is to assure that quality of care is maintained.

The Deductible Proposal

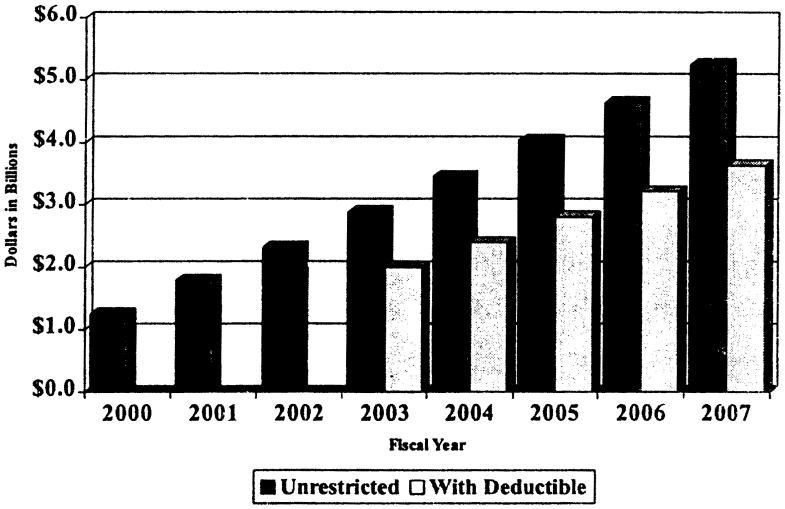
The table below shows the forecast of key workload factors including associated workload expenditures. Estimates are shown with and without the deductible in place for 2003. Priorities 1–6 veterans are VA's core veterans-service connected and low income—Priority 7 veterans—(higher income veterans, about $25,000 for a single veteran and $28,000 for a married veteran). As the table indicates, Priority 7 users are projected to rise by 43 percent from 2001 to 2003 and resource requirements by 61 percent without the $1,500 deductible. With the $1,500 deductible, the growth is held to 29 percent and 12 percent respectively

	2001 Estimate	2002 Estimate	2003 Without Deductible	2003 With Deductible
Priority 7 Enrollees (Average) in millions	1.4	1.9	2.2	2.1
Patients (unique)	841,153	1,060,482	1,206,860	1,085,074
Workload Expenditures in millions	$1,790	$2,320	$2,885	$2,000
Deductible Revenue in millions				$260

Application of the deductible proposal reduces Priority 7 veterans by 10 percent and their related workload expenditures by 31 percent in 2003. Their expenditures decline by a greater amount because a large portion of the veterans will seek fewer medical services from VA and will shift some of their care to other providers. The following graphic displays the Priority 7 expenditures projected for 2000–2007 with and without the proposed deductible starting in 2003.

DEDUCTIBLE IMPACT ON PRIORITY 7 EXPENDITURES

[ASSUMES ACTUARY'S FY 2003 PERCENTAGE IMPACT FOR OUTYEARS]



The actuarial estimate concentrates on medical procedures workload (outpatient visits—CPT codes and inpatient episodes of care—DRG) of Priority 7 patients, as this factor is more directly related to expenditures than the number of patients or enrollees. The actuarial expectation is that, with the application of the $1,500 deductible, VA will experience a 10 percent reduction in unique medical users (122,000), a 50 percent decline in outpatient procedures, a 40 percent decline in inpatient episodes of care, and a 10 percent decline in pharmacy utilization. The overall effect on resources is expected to be a 31 percent decline in cost.

Because this type of policy change has not been seen in any large health care system before, or in a system with similar characteristics to the VA—a system where the patient pays only a small fraction of their health care costs, the change in Priority 7 veterans behavior due to the introduction of a $1,500 deductible could be different than that forecasted. The ramification of expenditure savings and the impact on budgets in the future is very significant.

Revenue Estimate

The actuary estimates that this proposal will bring in an additional $260 million in revenue in addition to the $885 million in cost reduction for an overall reduction to the appropriation request of $1.145 billion.

Why This Proposal Was Chosen?

Continued growth in the demand for VA health care services will require significant increases in budget resources. Without significant increases in resources or the implementation of an alternative policy/policies (limit enrollment, change uniform benefits package, cost share proposal), VA would face critical issues impacting quality, such as, increasing waiting times, increasing system congestion impacting all patients, inability to meet demand. VA considered these policies and determined that the deductible (cost sharing) proposal seemed to be the preferable option that addresses the following most overarching concerns:

- Maintain quality of care for all those that VA serves
- Continue VA open enrollment for all veterans
- Maintain, not reduce, the basic benefit package of medical services for core veterans
- Provide veterans appropriate access to outpatient, inpatient, and non-institutional long-term care services
- Require veterans that have higher incomes to contribute more to their cost of care than other veterans
- Assess a charge for use of healthcare services as opposed to assessing an up-front charge or enrollment fee

• Allow veterans to benefit from private insurance coverage and encourage veterans to identify their insurance coverage and improve third party collections
• Continue VA long-term services, especially non-institutional care
• Provide catastrophic coverage for those with high annual medical costs

How does the Deductible Work?

Who pays the deductible?
• All Priority 7s for non-preventive, non-service connected care
• Insurance will help offset deductible charge to veterans
  Dollar for dollar
  Veteran will not be billed until insurance payment is made

How much is the deductible?
• Pay only for care received (no upfront charge)
• Once annual deductible ($1,500) is met, no more deductible for that year
• Excludes pharmacy (only $7 copay applies)

How do co-payments work with the deductible?
• Inpatient and outpatient copays start after deductible cap is reached
• Pharmacy copays will be in effect the entire year

How was the $1,500 cap determined?
• The deductible amount is below the average overall cost for priority 7 veterans ($1,900)
• Would encourage veterans to identify insurance
• The cap provides catastrophic coverage for those with huge annual medical costs
• Not likely to devastate those without insurance who need health care as the cost of most Priority 7's care is low, a greater share of their total cost is for pharmacy and a small percentage have large medical costs

Question 5c. Last year Congress passed Public Law 107–135, the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001, and one of the provisions in this legislation was geographic means testing for inpatient care copayments. How will this adjustment to inpatient copayments be affected by the new $1,500 deductible?

Answer. If VA is given legislative authority to implement the $1,500 deductible, a veteran will be required to meet the entire deductible amount prior to paying for regular VA copayments. There will be no change in procedure for veterans who will be subject to the geographic means test inpatient copayment. They will be charged the full amount of the deductible until that amount has been satisfied. Once that amount has been satisfied, then the geographic means test copayments for inpatient care will be assessed. At that time, veterans impacted by the geographic means test will be assessed regular VA copayments for outpatient care and extended care services.

Question 6. Considering last year's funding shortfall, does this budget provide for full and complete funding—above the FY 2002 baseline (which will not include the additional amount that was provided)—for veterans' health care, so that VA does not again face the dilemma of choosing which veterans to serve?

Answer. There are many variables that impact health care in general (new diseases, new treatments, inflation changes, etc.) and impact veteran enrollment in VA health care (other health care alternatives, availability and accessibility of VA services, etc.). This budget incorporates a "Base Health Care Demand Adjustment" initiative that identifies and requests the resources required to support an actuarial estimate of the demand and case mix changes needed for all seven patient priorities in FY 2003. Based on this initiative, this year's budget estimates should better account for the relationship of planned workload requirements and the full funding needed.

Question 7. Although I am pleased with the decision to continue enrolling new Priority 7 veterans in the current fiscal year, I remain very concerned about where the additional funding came from. I understand that a supplemental will be coming in the amount of $142 million to cover unforeseen costs in FY 2002. I understand, however, that the VA health care system was running a $400 million deficit. It seems that this supplemental is not sufficient. Where will the additional money come from?

Answer. Based on the continuation of full enrollment, VHA determined there would be a shortage of about $441 million in FY 2002, after available resources were subtracted from projected expenditures. Approximately $300 million in management savings is anticipated in FY 2002. These savings are expected to be generated from a multi-year effort to improve standardization and compliance in the procurement of equipment, pharmacy, and medical supplies. Other savings are expected from program efficiencies related to new criteria to assess community-based outpatient clin-

ics and centrally managed programs. The balance of the shortfall, $142 million, is required as supplemental funding in FY 2002 to continue enrollment of new priority 7 veterans.

Question 8a. The Medical Care Cost Fund takes on new importance in the budget. What is the status of the 24 initiatives in the Revenue Improvement Plan?

Answer. Attached is our Status of Revenue Improvement Plan Recommendations.

Rpt Item and Description	Action/Status	Date		Chg Due	Comments
		Complt	Due		
1. Mandate pre-registration of veterans	VHA Directive 98–042 issued 9/23/98. ADUSH memo dtd 12/10/01 to network and facility directors re-emphasizing requirement. Project Team will serve as Focus Group for the EDI Insurance Team. ADUSH issued memo dtd 12/26/01 summarizing Revenue Office action(s). Re-issue Directive scheduled for 2nd Qtr, presently in concurrence. Article for Fast Track Newsletter drafted, pending publication.	12/01/01	12/01/01	.....	Completed. Addtl followup required to monitor compliance.
2. Define standards for complete/accurate (insurance) data capture.	Project team established 12/01; Team meeting (conf call) conducted Feb 2002. Project Team will serve as Focus Group for EDI Insurance Team. Team Report on intake requirements for insurance data issued 02/02, and presently in clearance process. Guidelines to address procedural requirements during interim period prior to EDI implementation being drafted. Completion date is revised HIPAA deadline coinciding w/EDI implementation.	12/31/01	.....	10/30/03 *	In-Progress. EDI Team addressing long-range conversion. * Indicates revised HIPAA deadline.
3. Implement veteran education program	Pamphlets and posters on new copay amounts developed. Statement inserts distributed in January 2002 mailing. Inter/Intranet websites updated 01/02. An Education workgroup was formed 02/02 to collaborate WEES on education/awareness campaign.	12/31/01	1/31/02	.....	Initial distribution completed 1/02. Additional education/training program development in-progress.
4. Implement employee education program	Project team established 12/01; Team meeting (conf call) conducted Jan and Feb 2002. Additionally, the Education workgroup is coordinating with the (HEC) pre-registration workgroup in collaborating w/EES on education/awareness campaign.	12/31/01	.....	.....	In-Progress. EDI Team addressing long-range conversion requirements for IPAA implementation.

Rpt Item and Description	Action/Status	Date		Chg Due	Comments
		Complt	Due		
5. Implement electronic insurance identification and verification.	Project team established 12/01; Team meeting (conf call) conducted Feb 2002. Pilot in-progress in VISN 2. Project Team will serve as Focus Group for EDI Insurance Team. Completion date is the revised HIPAA deadline which coincides w/EDI implementation. Conference call with the EDI Team was held 02/02 to coordinate integration of both team's efforts in identifying system requirements and establishing business rules and models.	3/1/02	.....	10/30/03 *	In-Progress. EDI Team addressing long-range conversion. * Indicates revised HIPAA deadline.
6. Consolidate insurance information at the enterprise level.	Project team established December 2001. Results from VISN 2 Pilot (in-progress) may provide support to this item. Discussions w/St Anthony's Publishing and Ingenix ref: electronic insurance directory file in progress.	7/1/02	.....	.....	In-Progress.
7. Develop an employer master file	Project team established December 2001. Project team meeting (conf call) conducted Feb 2002. Identification of systems requirements in progress.	12/1/02	.....	.....	In-Progress.
8. Enforce national documentation policy	ADUSH memo dtd 12/10/01 issued to network and facility directors. Contract awarded to PwC on national documentation policy. Draft VHA Directive in progress.	11/30/01	12/10/01	.....	Completed. Addtl followup and monitoring required.
9. Mandate use of electronic medical records (CPRS)	ADUSH memo dtd 12/10/01 issued reminding network and facility directors of this requirement. Additional guidance published 1/30/02 mandating full implementation via EDMS (166245).	6/30/02	.....	8/30/02	Performance indicators to monitor CPRS compliance in approval process.
10. Develop national clinical education program	Mtg scheduled 02/11–12/02 in Minneapolis for development of (education/training) tool kit which is in progress.	12/31/02	.....	2/2/02	In-Progress.
11. Develop and mandate use of electronic encounter form and documentation template.	One encounter form developed and is in testing. Other encounter forms anticipated due by 2/28/02.	1/1/03	.....	.....	In-Progress.
12. Develop and implement Documentation tracking system.	Requirements identification in progress by Project team. Draft of VHA Directive in progress.	12/31/03	.....	.....	In-Progress.
13. Develop staffing plan for coding resources	Requirements identification in progress by Project team. Questionnaire in-progress. Recruitment and Retention Handbook in draft. Extension requested thru 3/30/02.	12/1/01	.....	3/30/02	Questionnaire in-progress. Recruit/Retention Handbook in draft.

14. Mandate use of encoder software	ADUSH memo dtd 12/10/01 issued to network and facility directors. Followup required to monitor implementation of encoder software.	12/31/01	12/10/01		emo drafted on use of standard software in review by CIO.
15. Develop national standard for laboratory, radiology and other ancillary test names and corresponding CPR codes.	Project Lab and Radiology subteams reviewing (VistA) clinical packages to determine feasibility of subroutines tied to national annual CPT roll out to update all xray/lab and ancillary codes.	3/29/02			In-Progress.
16. Mandate minimum access policy to VistA ancillary packages.	ADUSH memo dtd 12/10/01 issued to network and facility directors. Additional guidance in draft to network and facility directors to provide minimum access to field Revenue Staff is in progress.	12/1/01	12/10/01		Completed. Addtl followup via joint CIO/ADUSH memo scheduled for 02/02
17. Complete implementation of:					
EDI Billing Project	National training completed in Chicago and Atlanta. Site testing in progress.	12/31/01	12/31/01		In-Progress. Systems capacity testing successfully completed 02/02.
MRA Project	Alpha testing in progress. Identification of Systems Requirements Specifications anticipated 05/02. Completion date is revised HIPAA deadline.	4/30/02		10/01/03 *	In-Progress. * Indicates revised HIPAA deadline.
18. Implement claims analyzer tools		3/29/02			In-Progress. See Item #14.
19. Improve the charge capture process	Project Subteams reviewing high dollar volume clinical packages for billable events. CIO billing package plan development in progress. Project Team meeting scheduled for 03/02 to conduct requirements analysis and develop systems specifications.	10/1/03			In-Progress.
20. Consolidate/outsource VHA 3rd party accounts receivable follow-up.	ADUSH memo dtd 12/10/01 issued to network and facility directors, RFI closes 2/6, RFP follows. Extension due to contracting and budget constraints. PwC contract for development of CIP for nationwide contract solution, Requirements analysis and draft of proposal in progress. 90 day pilot in VISN 12 in progress to collect on aged receivables thru private vendor.	12/31/01		8/30/02	
21. Develop utilization review program	Project Team drafting SOPs, policy, position description & identifying software enhancements. Project Scope change to include Web-based training module, national UR training initiative & proposing more software enhancements for UR activities extends due date to 9/30/02. Questionaire administered 12/01.	3/29/02		9/30/02	In-Progress. Questionaire results under review.

Rpt Item and Description	Action/Status	Date		Chg Due	Comments
		Complt	Due		
22. Request VA GC more aggressively pursue referred 3rd party AR.	Discussions w/OGC held Dec 2001, Jan and Feb 2002. Meeting planned for Jan/Feb w/Project Subteam Leaders.	4/1/02	.....	.....	In progress. On 03/05/02, the Office of General Counsel released instructions to Regional Counsels for reconciling accounts with VA Medical Centers.
23. Implement 3rd party payment and remittance program (EDI Lockbox).	Project team (Mellon Bank, AAC and Technical Development Staff of Revenue Office) established. Systems requirements identified, currently in design. Systems stress testing completed 2/19/02. Software deployment anticipated Apr/May 02.	1/1/03	.....	10/01/03	In-Progress.
24. Implement accounts receivable management software.	UNISYS providing DEMO of product currently in use in Pitts VAMC. Visit to Asheville CRU scheduled January 2002. RFI in progress for assessment of additional vendor/products. Other CRUs to view demo @ Pitts, VAMC 03/02.	6/2/03	.....	.....	In-Progress.

Question 8b. What is VHA doing to reduce the third party accounts receivable backlog?

Answer. VHA is currently in the process of conducting market research through a Request for Information (RFI) to identify private sector practices that can readily be adapted to VA's business operations and thereby align VA with industry hallmarks. VHA plans to release a Request for Proposal (RFP) soliciting bids for third-party accounts receivable management by Spring 2002 and to award one or more contracts by Fall 2002. Simultaneously, VHA initiated a contractor pilot in VISN 12 to resolve third-party accounts receivables greater than 90 days. The contractor will be doing all follow-up actions on these accounts.

Question 8c. Despite the recent improvements in developing better billing methods, I think there is general recognition that VA's collections efforts could be much better. Please compare VA's costs to collect third party revenue with the costs of private industry.

Answer. VA's cost to collect from third-parties is very difficult to compare with private industry's cost to collect. VA's measurement for this process is a cost to operate. VA's data systems cannot provide data for collections and costs to differentiate between first and third-parties. The cost accounting system records only total collections and cannot identify cost expenditures to the first and third-party level. There have been cost assessment studies done in prior years by contractors and one currently underway; both of which have shown (show) how the cost to collect/operate has declined over the past few years. This decrease in cost to operate can be attributed to a number of improvements in the process for billing and collecting of first and third-party receivables. These enhancements include the electronic generation of patient statements from one location, the receipt of payments for first party charges through a lock box bank, and the automatic posting of those payments to a patient's account. Additionally, improvements made to the third-party billing process include facilities using an Electronic Data Interchange (EDI) process to submit a bill to an insurance company in the near future, centralization/consolidation of like functions, and outsourcing/contracting out.

Systems Flow, Inc., has been contracted to study and develop annual reports to Congress on an assessment and an interim evaluation of alternative business models presented in VHA's Business Plan for Revenue Collection. Systems Flow, Inc. reviewed three VISNs on various subject matters including cost to collect data. A draft based on preliminary data results (using December 2001 data) was issued February 12, 2002. The cost to operate on average for three VISNs for third-party collections averaged 22 cents to collect $1 and averaged 16 cents to collect $1 of total collections (first and third-party).

Question 8d. Three years ago VA began an initiative to test contracting out its Revenue Process. I understand that this effort never achieved its intended goal of a complete contracting out of all billing and collection activities in two VISNs. Why wasn't it fully contracted out and when will we see the report on this pilot?

Answer. As you note, several years ago VHA undertook an initiative to evaluate whether it was feasible to contract out the Revenue process or parts of the process. Unfortunately, that initiative has not produced the positive results that were anticipated. Volunteer VISNs were sought to pilot the contract and franchise revenue collection models, and VISN Directors provided constructive comments and recommendations. This approach, however, did not provide as many positive results as expected. Many VISNs sought autonomy in tailoring the models to their organizations. That later turned out to be a major impediment to the pilot's efficacy. Nevertheless, other contracting-out related initiatives are currently being pursued.

Question 8e. Does VA anticipate changing the prescription or outpatient copayment amounts in FY 2003?

Answer. As VHA indicated in the final regulation regarding the medication copayment, the medication copayment will be reviewed on an annual basis and increases will be based on the Prescription Drug Component of the Medical Consumer Price Index. This is most relevant to the cost of prescriptions and should be relevant to any general increases in medication copayments in the private sector. VHA will also periodically review the outpatient copayments and will recommend adjustments as appropriate.

Question 9. I understand that the VA is considering requesting legislation to authorize Medicare Subvention. How much did DOD gain or lose in revenue as a result of their pilot program? Given DOD's experience, how do you believe VA would fare?

Answer. VA is currently in the process of discussing some options for Medicare coordination of benefits with the Centers for Medicare and Medicaid Services (CMS). CMS and VA are positioned to begin exploring some options for improving federal efficiencies through the provision of choices for the veteran beneficiary. These efforts

could result in high quality, comprehensive, unduplicated, and coordinated care within a national health care environment.

While the overall gains or losses from the DOD demonstration are not available (only FY 1999 figures have been released by GAO), reports have been released addressing the increased costs to DOD as a result of the demonstration. DOD faced significant challenges during the demonstration. VA expects to face some of the same, and some very different challenges. The Administration is studying the issues.

Question 10. What efficiencies could be gained from centralizing contracting decisions for CBOC's, personal services, and other clinical services? What oversight does headquarters staff currently exercise on these issues?

Answer. Efficiencies could be gained in developing a pool of acquisition specialists who are expert at this type of contracting. Additionally, standardized quality and patient safety requirements could be included in all contracts. However, it would be difficult to determine specific requirements because those issues are driven by local clinical circumstances. VHA is developing a policy directive on health care contracts that will require a review process for significant dollar volume health care contracts. Additionally, pursuant to the policy directive VHA will require specific language that addresses quality and safety in all health care contracts.

Currently, headquarters staff review and approve all 38 U.S.C. 8153 contracts for clinical services, including CBOC contracts, that satisfy certain monetary thresholds. As a result, headquarters staff, including Strategic Healthcare Group Chief Consultants, Office of Acquisition and Materiel Management, and General Counsel, thoroughly review all CBOC contracts that exceed the monetary thresholds prior to approval. Such reviews include the submission of veteran population data, alternative methods for delivering care, and estimated costs associated with the proposed CBOC. Once expert headquarters staff reviews the submitted information, the National Leadership Board does the same. Moreover, subsequent to awarding a CBOC contract, the CBOC contract may be audited by the Office of Acquisition and Materiel Management. This subsequent audit is considered part of the ongoing Business Review performed at the VHA contracting activity.

Question 11. What mechanism do you have in place to guarantee quality of care in contracted CBOCs and how much money is in the budget for quality management programs at CBOCs?

Answer. VHA's ability to measure and report on quality of care allows VHA to identify areas for improvement at all system levels. Quality management is embedded in VHA's core processes through performance measurement. Recent initiatives are underway to enhance the value of performance data provided. For example, the VHA Office of Quality and Performance (OQP) provides field and Central Office leadership with routine reports on actual and comparative performance data at the network level, coupled with information on successful approaches for improving performance. This synergistic approach supports management by linking strategy with relevant measurement regarding actions intended to improve the quality of care.

In late FY 2002, OQP will increase the frequency of outpatient satisfaction, functional assessment, and health behavior surveys (from annually and semiannually) to quarterly to improve the timeliness of data. Analyses will include not only Network comparisons of performance, but also periodic CBOC, special population, or cohort analyses to assure that data provides more valuable guidance and clearer direction for improving care. Finally, sampling methods are being modified to assure that OQP is maximizing the power of analyses wherever possible. Performance analyses, powered for specificity at the particular CBOC level, would require additional funding and would be predicated on adverse finds at a more aggregated level.

There is no specific line item in VHA's budget identified as CBOC quality management. The quality management activity is matrixed throughout the organization and quality is monitored at all sites of care through the activities of many employees at the Central, Network, and local level. The costs that could be attributed to CBOC quality management within Central Office's Quality and Performance Office are roughly $3.5 million. This figure includes costs associated with External Peer Review Activities, veteran satisfaction and functional status surveys, utilization management guidance, and credentialing support. It does not include Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation costs—which are difficult to attribute because they are facility-wide expenses. It also does not reflect the local and Network operational costs (e.g., medical center quality managers, network quality management officers, local training, etc.). There is no local quality manager at the CBOC-rather, this function is subsumed by the local quality management staff that are responsible for managing the quality at all sites of care affiliated with the local facility. Additionally, CBOC contracts include requirements designed to ensure quality care for veterans.

Question 12. Is there a central data bank that VA field contract specialists can use to assess the value of the contracts that they are negotiating?

Answer. Yes. Contract Specialists are given information on how to assess the value of contracts they negotiate. Examples include salary schedules for medical school affiliate physicians and Medicare websites with specific rate schedules for their vicinity. Another tool for negotiating costs is use of Medicare rates for both technical and professional medical services for the local area. These are established and verified rates and can greatly assist the contract specialists in awarding cost-effective contracts.

Question 13. What are the cost estimates for implementation of the chiropractic provisions of Public Law 107–135 in FY 2003?

Answer. VHA estimates that $7.5 million will be required in FY 2003 for this program.

Question 14a. Sharing between VA and DOD is a key element in this budget. What is the status of the VA relocation to Fitzsimons? How does this impact CARES?

Answer. Since its inception the Denver VAMC has had an affiliation with the University of Colorado Health Sciences Center (UCHSC). This affiliation has served to enhance the provision of health care to veterans. UCHSC is now moving to the former Fitzsimons army base in Aurora, which is in the eastern part of the Denver metropolitan area. The University of Colorado Hospital (UCH) will soon be part of this move. In fact, it has already established a major presence with the Anschutz Center for Advanced Medicine, a major ambulatory facility, and has begun construction of a 12-story inpatient facility at the location. The University and LICH will be part of a larger complex that is anticipated to draw world-class research and developmental talent and resources.

The move of the University and UCH to Fitzsimons presents both challenges and opportunities for the VA. The future of the VA at the present location is problematic. Continued remodeling will not yield an optimal result and the recruitment of physicians and other medical staff will be much more difficult without the University adjacent to the Denver VAMC. These concerns have led VA leadership to examine the possibility of moving VA health care to Fitzsimons through enhanced partnership with UCH. Three options are under study by the VA.

Option A—Build a freestanding VA Hospital adjacent to UCH
Option B—Build a VA Bed Tower/VA Clinic attached to UCH
Option C—VA Outpatient Clinic and merged Hospital

VA has contracted with a consultant to help us further evaluate the pros and cons and the costs of relocation of the Denver VA Medical Center to the Fitzsimons campus. They are also assisting in preparing a Capital Investment Application for this project, which will include a financial analysis of several scenarios for relocation. The analysis will include demand projections and service needs through the year 2020. It will also consider the residual value of the existing land and facility as well as the cost associated with each scenario. Their work is scheduled for completion in late Spring 2002. Until that work is completed, VA is not able to make a decision about the optimal solution for the future location on the Denver VAMC. This timetable did not permit the project to be included in the President's budget for FY 2003.

The consultants who are assisting the VA and the University are familiar with the CARES process and criteria. As noted, projections of demand and service needs are being made through the year 2020. The ongoing evaluation of the potential relocation of the Denver VAMC to Fitzsimons is highly compatible with the letter and the spirit of the CARES initiative. The planning for this project will be incorporated into the CARES study for VISN 19 and assessed during the CARES review process.

Question 14b. What is the status of the VA/Tripler joint venture? How does this impact CARES?

Answer. In May 2000, the VA activated a new Ambulatory Care Center on the Tripler campus and relocated the administrative offices of the VAMROC. In addition, VA has a 60-bed Center for Aging on the campus and staffs a 20-bed psychiatric unit within the Tripler Medical Center. The VA continues to contract with Tripler for most of its inpatient medical and surgical needs.

The recent relocation of VAMROC Honolulu to Tripler campus has increased congressional interest in moving towards creation of an integrated federal medical center to provide seamless health care services to active duty members, retirees, military dependents, veterans and other federal beneficiaries in Hawaii.

Congress is requiring that three sites be selected as pilot projects to pursue additional integration of services between VA and DOD facilities. Tripler Army Medical Center was mentioned in congressional language as a site that should be considered for one of the pilots. VHA supports including Tripler, which is one of the most functionally integrated VA/DOD joint venture sites in the nation.

The planning and potential changes to the VA/DOD joint venture will be incorporated into the CARES study for VISN 21 and assessed during the CARES review process.

Question 14c. How much progress has been made on the VA-DOD joint efforts to develop a compatible computer-based patient record to support post-separation health care delivery and claims processing?

Answer. VA and DOD began a substantially expanded effort last fall entitled Health*e*People (VA, DOD, Indian Health Service (IHS), other agencies) and Federal Health Information Exchange (DOD, VA and IHS), to: improve sharing of health information; develop and adopt common standards; seek appropriate opportunities for joint procurements and/or building of systems; work toward improved, model health information systems; and explore the potential convergence of VA and DOD health information software applications.

The specific actions that are being taken include the following:

- DOD is establishing a national patient record using a Health Data Repository product from 3M;
- VHA intends to pursue a comparable solution and has staff working with DOD on a regular basis;
- DOD and VA will have separate repositories in order to ensure privacy, security, and reduce the consequence of any failures. Both DOD and VA repositories should be up and running by 2005 and would use common data standards and support retention of records from DOD and VHA;
- VHA intends to explore with DOD the potential to create a second phase to this effort that supports creation of government-owned repository architecture/software, not dependent on vendor technology. This architecture/software could also be used throughout government to create health care repositories that can easily share patient information;
- VHA and DOD are also standing up a national repository, which may be temporary, under Government Computer Patient Record (GCPR) that allows for sharing of select DOD patient data at VHA locations. Additional phases of this project will support DOD viewing of VHA information.

The VA/DOD Executive Council Information Management and Information Technology Work Group manages the VA/DOD interagency Government Computer Patient Record (GCPR) program, to be renamed the Federal Health Information Exchange. The goal is to make DOD data available to VA clinicians with the highest functionality at the lowest cost. The transfer of DOD data to VA is in the testing phase. As part of the FY 2002 budget process, VA and DOD funding has been apportioned for development of a business case plan and implementation plan to address the interoperability of GCPR with CHCS II (DOD's new system in development) and VistA (VA's patient information system).

Additionally, the VA Deputy Secretary and the DOD Under Secretary for Personnel and Readiness have agreed to conduct quarterly reviews of VA-DOD coordination initiatives. Other information technology sharing efforts underway between DOD and VA include: Health Insurance Portability and Accountability Act of 1996 (HIPAA); standards development; pharmacy initiatives; technology integration laboratories; VA/DOD Laboratory Data Sharing and Interoperability; and collaboration for a VA/DOD Consolidated Mail Order Pharmacy (CMOP) pilot.

We have provided a list of additional joint efforts in the attachment accompanying this question. Additional details are available for each.

ATTACHMENT

Specific joint IT efforts between VA and DOD intended to ultimately support post-separation health care delivery by VA are:

- IT sharing efforts underway between DOD and VA, including:
  - Health Insurance Portability and Accountability Act of 1996 (HIPAA) implications for IT
  - IT Standards Development
  - Pharmacy Initiatives (more details below)
  - VA/DOD Laboratory Data Sharing and Interoperability (more details below)
  - Software Technology Integration Laboratory
  - Support for VA/DOD joint venture local R&D initiatives
  - TRAC^{2}ES System (more details below)
  - Collaborating in such areas as Scheduling System Replacement, Billing System, VA/DOD Consolidated Mail Order Pharmacy (CMOP), Health Data Repository, Web Based Consumer Health Information System, IT Architecture and Standards
- VA/DoD Consolidated Mail Order Pharmacy (CMOP) Pilot Project

Progress is being made to enable DoD to use VA's Consolidated Mail Order Pharmacy. A prototype will be tested late in FY 2002

- Other Pharmacy Initiatives

The MHS is discussing VA participation in the Pharmacy Data Transaction Service (PDTS), which allows DoD to build a patient medication profile for all beneficiaries regardless of the point of services

- VA/DoD Laboratory Data Sharing and Interoperability

This project focuses on development of an interface for electronic transfer of reference laboratory data between federal health care systems (various DoD Composite Health Care System sites, VA's Veterans Health Information Systems and Technology Architecture sites, and commercial reference laboratories) to replace current manual methods. The Preliminary System Testing is underway.

- The TRANSCOM Regulating and Command and Control Evacuation System (TRAC^{2}ES)

Provides global patient evacuation planning in an integrated system. It facilitates the decision-making process of evacuating military casualties from a combat theater to a source of definitive medical care within the continental United States. Emergency management personnel within VHA facilities have the ability to use TRAC^{2}ES to submit bed reporting and contingency data information to DOD.

Per the "Report of the Preparedness Review Working Group to the Secretary of Veterans Affairs" recommendation in October, 2001: Goal is to provide information on the capabilities of VA health care facilities to the Global Patient Movements Requirements Center (GPMRC) and incorporate that data into TRAC^{2}ES so that the U.S. military can evacuate wounded military personnel to an appropriate VA facility.

Question 15. What are the implementation costs associated with the consolidation of VISNs 13 and 14? What are the first year savings?

Answer. The start-up costs associated with the integration of the two VISNs are not anticipated to be significant. While the merger, in and of itself, will not bring financial stability to VISN 13 and 14, the integration is expected to generate cost savings through economies of scale and reduced administrative overhead. The precise programs where these efficiencies will be obtained is not determined at this point, but the leadership at the network and facility level have already begun the task of sharing best practices and possible avenues through collaboration that they can obtain management efficiencies. The cost savings gained will be redirected into veterans healthcare services throughout the integrated network.

Question 16. What adjustments to VERA will be put into place in FY 2003 and what is being done by headquarters to reduce the need for supplemental funding by VISNs?

Answer. For the FY 2003, VHA is continuing to review VERA to improve the equitable allocation of funds, including all Priority 7 and improving the case-mix weighting and risk adjustment elements of VERA. Decisions on these adjustments will be made later this fiscal year. Also, during FY 2001, VHA re-engineered its VERA adjustment (supplemental funding) process. The process now involves a thorough review of each networks' financial plan by assessing projected revenues versus expenses in a systematic standardized approach across networks. VHA plans to complete the FY 2003 VERA adjustment process prior to distribution of the FY 2003 network allocations, after VA receives its FY 2003 Medical Care Appropriation.

Question 17. As I understand it, under the proposed long-term care copayment regulations, the monthly long-term care copayment can be over $3,000. A veteran whose annual income is just over $9,000 is required to make these copayments. With the average long-term care stay being 13 months, the proposed copayment structure could either bankrupt veterans or, even worse, deter them from using VA services. What, if anything, is VA doing to ensure that this does not happen?

Answer. VA has developed procedures, through the calculation of the financial cap, to avoid a veteran and spouse from incurring a financial hardship.

For any month, the maximum copayment amount a veteran will be charged is $97/day times the number of days in the month ($3,007 for 31 days; $2,910 for 30 days). A veteran's calculated monthly copayment cap amount for extended care services is determined by a formula using financial data provided by the veteran. The amount will vary from veteran to veteran and can range from $0 to the maximum copayment amount.

A veteran will be obligated to pay the extended care copayment only to the extent the veteran and the veteran's spouse have available resources. Available resources would mean the sum of the value of the liquid assets, fixed assets, and income of the veteran and the veteran's spouse minus the sum of the veteran allowance and

the spousal allowance. Liquid and fixed assets are not included in the copayment calculations until a veteran reaches the 181st day of institutional/inpatient extended care. The primary residence is a fixed asset, the value of which is only included in the veteran's copayment calculation on the 181st day of institutional/inpatient extended care if there is no spouse or dependent residing in the primary residence.

Question 18. VA is moving its National Centers for War-Related Illnesses. However, a final action plan to implement the National Center for Military Health and Deployment Readiness is long overdue. The law requires that VA, DOD, and HHS submit a report to Congress about how they will implement the center. Both VA and DOD seem to be satisfied with the current activities of the Military and Veterans Health Coordinating Board, which does not incorporate the National Academy of Sciences' recommendations as mandated. Although it is certainly difficult for three large departments to focus on a matter of joint concern, this is critically important to service members. When can I expect to see your action plan on this?

Answer. In compliance with section 103(c) of Public Law 105–368, the Departments of Veterans Affairs, Health and Human Services, and Defense prepared a report to Congress responding to the IOM report "National Center for Military Deployment Health Research." That report, signed by the Secretaries for the three agencies, was submitted to Congress in September 2000. That report concluded that the new National Center be composed of the existing Research Working Group (RWG) of the interagency Military and Veterans Health Coordinating Board (MVHCB). Since that report, the RWG has partially fulfilled the role envisioned for the National Center, in terms of generating research reports on existing Gulf War research, identifying gaps, and making recommendations for improving research in this area.

The MVHCB was decommissioned in February of this year. The future of the RWG under these circumstances has not been decided. However, we expect that the RWG will continue in some form, and that it will be responsible for the activities envisioned for the National Center, as it has over the last several years.

Question 19. Last fall, VA commissioned a working group to review VA's readiness for the potential medical consequences of terrorism. The group recommended a budget of $118 million for health care preparedness needs alone; this budget proposes to accomplish these goals, plus boosting VA's other readiness activities, with less than half of that amount. Given the discrepancy between VA's own internal recommendations and the budget, how many of these emergency preparedness goals will VA realistically be able to meet? Will VA be able to protect staff and veterans adequately during a medical crisis?

Answer. Following the September 11 attack, as well as the bioterrorism campaign using the anthrax sent in the U.S. Mail, VA critically re-examined the potential medical consequences of terrorism and looked at gaps in the protection of VA's capital assets, its infrastructure, as well as patients and staff. VA needs to insure adequate supplies, pharmaceuticals, and decontamination and Personnel Protective Equipment (PPE) are available in case of mass casualties from chemical, biological, or radiological (CBR) terrorism.

VHA is currently upgrading its pharmaceutical caches, PPE, and training in FY 2002. We are committed to making this program fully operational in the near-term.

Question 20. The CARES process went on in the Great Lakes Network as planned, despite new emphasis on the VA's Fourth Mission and its role as a Federal support agency during disasters. This budget continues to cite CARES as a source of significant savings, while funding for VA's contingency roles remains woefully inadequate, especially as compared to the large sums budgeted to other agencies for emergency response. How does VA plan to weigh DOD contingency and emergency care criteria, including community needs, as you continue with the next phases of the CARES process, and how will other planning aspects be affected?

Answer. VHA re-evaluated the Great Lakes Network ability to meet its Fourth Mission responsibilities during the review and public comment period on the CARES recommendations. In particular, the overall CARES Criteria was re-structured by VA's Policy Board to raise the Fourth Mission priority from an 8 percent to a 20 percent weighted score. This 2.5 fold increase was then applied for impact and analysis to each of the options considered. It was found that no decrease in bed numbers or ability to deliver health care by VA exceeded the projected overall decrease in veteran population. In other words, if the veteran demand for services in the next ten years decreased by 28 percent, a comparable adjustment in inpatient and outpatient services resulted. No reductions above the 28 percent were made. VA continues to interact with DOD to determine if there is a threshold or minimum number of services necessary for backup contingency. At this point, no such minimum level has been determined by DOD. Future CARES studies will undergo increased emphasis on VA's Fourth Mission. A new VA/DOD Executive Committee has been

formed to fully coordinate VA CARES and DOD strategic planning efforts. All of these efforts combine to provide significant additional emphasis and attention to our Fourth Mission. The VISN 12 CARES plan has sufficient flexibility to address DOD contingency and responses to chemical, biological and radiological emergencies.

Question 21. I understand that VA is moving both substance abuse and PTSD funds from special purpose funds into VERA. What is the reason for this and won't this have a negative effect on these programs in that they won't get the attention that goes along with being a specific budget item?

Answer. Substance Abuse and PTSD have always been included in the VERA General Purpose Funding and distributed through the VERA model. Both classes are included in both Basic Care and Complex Care components of VERA. This has had no demonstrated negative impact on these programs. These programs receive positive attention not only in VERA, but also through quarterly monitoring of cost and utilization of special programs in operating plans and special disabilities reports to Congress.

Question 22. Please provide a list and a description of the management efficiencies that VA is counting on to save $316 million in medical care funding in FY 2003.

Answer. The savings of $316 million will be achieved through standardization and compliance in the procurement of supplies, pharmaceuticals, equipment, and other capital purchases and through efficiencies in centrally managed programs and Community-Based Outpatient Clinics.

Question 23. Please provide a list, by state, of all enrolled veterans by priority group.

Answer. See attached table.

ATTACHMENT—SUMMARY BY STATE & PRIORITY

End of Fiscal Year 2001 Geocoded Enrollment Data

State	Priority Group								Total Enrollees
	P1	P2	P3	P4	P5	P6	P7A	P7C	
Alaska	3,177	2,126	3,149	337	6,059	325	409	4,671	20,253
Alabama	11,446	9,042	16,932	5,060	42,179	2,006	1,410	24,051	112,126
Arkansas	10,444	6,334	11,769	3,879	34,092	1,536	1,178	21,359	90,591
Arizona	13,344	9,689	19,747	3,667	44,620	2,765	2,005	30,603	126,440
California	44,136	32,990	64,746	13,855	185,116	8,538	7,230	115,309	471,920
Colorado	9,507	6,886	11,940	2,415	25,470	1,487	1,377	17,618	76,700
Connecticut	4,248	3,079	7,073	2,291	21,683	837	898	25,679	65,788
Delaware	1,459	1,170	2,257	439	6,632	204	233	5,854	18,248
Florida	47,283	30,888	65,001	14,090	162,135	7,233	7,772	138,250	472,652
Georgia	16,548	12,720	24,032	5,762	55,861	3,093	2,579	36,269	156,864
Hawaii	3,085	2,449	4,310	491	7,356	273	660	6,315	24,939
Iowa	4,706	3,590	7,586	2,336	22,847	1,869	796	29,958	73,688
Idaho	3,320	2,440	4,910	1,184	11,239	637	660	7,870	32,260
Illinois	11,667	9,941	23,487	8,634	90,699	4,243	2,651	79,126	230,448
Indiana	8,521	6,746	14,553	3,587	43,451	2,251	1,216	37,738	118,063
Kansas	4,937	3,700	7,780	2,085	19,338	1,201	1,107	20,540	60,688
Kentucky	9,096	6,634	12,365	3,447	40,253	1,832	1,025	24,170	98,822
Louisiana	9,259	6,368	12,537	4,817	45,244	2,278	1,069	19,157	100,729
Massachusetts	13,161	8,448	16,847	3,913	37,125	1,832	1,290	30,386	113,002
Maryland	8,694	6,751	12,608	2,898	38,141	1,603	1,034	24,904	96,633
Maine	5,855	2,791	4,859	1,267	12,378	632	483	10,279	38,544
Michigan	10,771	8,185	16,819	4,543	55,072	2,142	1,503	31,672	130,707
Minnesota	8,794	5,825	12,443	2,853	25,708	2,423	1,984	29,889	89,919
Missouri	10,514	7,946	15,735	4,955	50,419	2,966	1,540	32,786	126,861
Mississippi	7,344	4,802	9,384	3,217	31,760	987	1,042	17,677	76,213
Montana	3,000	2,044	3,866	844	10,449	638	491	9,281	30,613
North Carolina	19,445	14,603	25,373	5,999	56,758	3,738	2,106	38,234	166,256
North Dakota	1,400	1,066	2,408	586	5,584	345	370	8,857	20,616
Nebraska	4,527	3,314	5,895	1,513	14,818	717	791	16,659	48,234
New Hampshire	3,407	2,336	4,517	819	8,393	489	516	8,351	28,828
New Jersey	10,389	7,596	17,297	2,995	37,274	1,476	1,753	57,747	136,527
New Mexico	6,697	3,799	6,768	1,648	20,501	1,124	823	10,678	52,038
Nevada	4,811	3,818	7,952	2,016	24,508	1,094	1,015	15,513	60,727
New York	26,025	18,627	46,557	11,388	148,286	6,509	6,003	175,111	438,506
Ohio	16,463	13,093	27,683	7,589	102,292	4,022	2,442	57,416	231,000

Oklahoma	13,446	7,657	12,279	4,192	35,165	1,887	1,002	17,625	93,253
Oregon	9,505	5,765	9,888	3,112	31,144	1,737	1,055	22,646	84,852
Pennsylvania	21,049	15,034	31,840	8,741	114,788	4,503	3,845	101,078	300,878
Rhode Island	2,505	1,600	3,355	737	8,063	353	214	6,128	22,955
South Carolina	10,184	7,653	15,083	4,264	37,717	2,517	1,824	26,354	105,596
South Dakota	2,249	1,681	3,638	1,023	9,149	797	603	11,585	30,725
Tennessee	12,920	9,406	17,795	5,191	46,138	2,907	1,638	26,771	122,766
Texas	46,057	33,250	62,664	14,075	153,685	8,549	6,019	84,808	409,107
Utah	3,153	2,217	4,261	1,069	11,524	767	542	8,501	32,034
Virginia	16,149	13,473	23,016	4,510	48,761	2,567	2,656	36,891	148,023
Vermont	1,441	993	1,926	411	5,696	361	307	6,095	17,230
Washington	17,672	12,093	20,163	4,224	34,751	2,283	1,554	21,117	113,857
Wisconsin	9,628	6,758	13,111	3,399	,32,710	2,083	1,724	34,966	104,379
West Virginia	6,291	3,786	7,098	2,168	30,986	1,957	626	20,133	73,045
Wyoming	1,327	1,080	2,241	524	6,260	347	367	6,707	18,853
Unknown	426	261	503	92	1,299	45	39	1,395	4,060
Guam	216	189	325	16	386	31	49	219	1,431
Philippines	261	345	529	17	207	24	38	105	1,526
Puerto Rico	7,978	3,622	7,078	4,424	43,156	1,041	484	6,878	74,661
Virgin Islands	103	95	263	66	1,050	31	45	930	2,583
Washington, DC	1,187	855	1,715	721	7,102	346	135	2,455	14,516
Total	561,227	399,649	789,956	200,395	2,203,477	110,478	84,227	1,663,364	6,012,773

P7A 0% Service-Connected Priority 7s.
P7C Non-Service-Connected Priority 7s.

Question 24. This budget breaks out and requests funds for the accrued employee costs such as retirement and health benefits that use to be consolidated government-wide, in compliance with the Administration-proposed "Managerial Flexibility Act." The budget reflects this change as an increase to the various accounts such as health care, general operating expenses, or research. But it is not a real increase. Are you expecting additional money on top of the 2.9 percent to cover these accrued benefits costs to fund VA programs such as research, at the touted $409 million, or will the real number be $38 million less—$394 million?

Answer. The FY 2003 appropriation request for research excluding the CSRS accrual ($6,258,000) and the FEHB accrual ($8,444,000) is $394,373,000, which represents a 6.3 percent increase over the FY 2002 appropriation of $371,000,000.

BENEFITS

Question 25. The budget request calls for an increase of 125 FTE for benefits programs, but according to a briefing by the Department of Labor, 200 FTE are required to administer the VETS programs that are proposed to be transferred. Do you anticipate additional FTE if the transfer is authorized, or would the net effect be a loss of 75 FTE to VBA?

Answer. The FY 2003 budget request does not include any FTE or funding to support the transfer of the VETS programs to VA. The Administration will transmit legislation that will establish a new competitive grant program in VA that will assist the States in establishing, expanding, or improving training services for veterans. If enacted, 199 FTE and $20 million will be transferred from the Department of Labor to VA to administer the program.

The increase of 125 FTE shown in VA's budget request supports initiatives in the C&P, Education, and Vocational Rehabilitation and Employment programs.

Question 26. In evaluating the success of VA programs and crafting new legislative initiatives, Congress depends on VBA's Data Management Office to deliver accurate information—for example, the regular reports on Gulf War veterans' claims, which in the past proved to be less than reliable. What will you do to ensure the validity of the data you provide to Congress?

Answer. The creation of the Data Management Office reflects the organizational recognition of the value and importance of quality data and information management across VBA. We intend to build on the established data management foundation, refining and enhancing existing capabilities and carefully exploring opportunities for blending organizational knowledge with emerging technologies. All of this is being pursued to improve the quality, integrity and availability of data that speak to VBA workload and productivity, organizational performance, and service quality.

Consistent with themes expressed in the recently released VA Claims Processing Task Force Report, efforts are also being directed toward the development of data that accurately gauge accountability, communications and change management compliance. Plans are being formulated to expand the current scope of data management by formally establishing internal analysis and evaluation, planning, and program integrity capabilities to further identify data-driven process and service improvement opportunities.

Understanding that multiple factors (including volume, source, input accuracy and timeliness) ultimately influence data validity, we believe the strategy being executed within VBA to better qualify and define the variables affecting data validity and to engage staff and stakeholders in decision dialogue is an appropriate course of action.

Since November 1997, the Gulf War Veteran Information System has been reliably reporting data specific to the outcomes of compensation claims including those for undiagnosed illnesses, prevalence of service-connected conditions, and detailed benefit utilization data regarding other unique cohorts of the Gulf War veteran population. We will continue to work to refine and improve the quality and reliability of data collected and reported.

Question 27. Under the budget's VBA-wide initiatives, you list the "Procedures Manual Rewrite" to reorganize and make more readable the procedural manuals used in decision making for the Education, Loan Guaranty, and Vocational Rehabilitation and Employment programs. Why is the Compensation and Pension (C&P) program manual not part of this initiative? How does the regulation rewrite lead by General Huffman underway in C&P fit in with this manual rewrite?

Answer. The Compensation and Pension Service began an initiative to rewrite its procedural manual 14 months ago. All of the adjudicative manuals used to process C&P claims are being rewritten for clarity, readability, and ease of use in an online environment. Initial feedback has been positive and VIBA is therefore under-

taking similar projects in the other business lines (Education, Loan Guaranty, and Vocational Rehabilitation and Employment).

The C&P manual rewrite initiative is being coordinated with General Huffman's effort to reorganize and clarify the regulations. Any regulatory changes affecting the manual will be incorporated effectively and timely.

Question 28. Please describe the collocation/relocation projects in the budget request for VBA.

Answer. VIBA is pursuing public/private partnerships for enhanced-use leasing at several Regional Office locations. The FY 2003 budget request supports co-locating the following VA Regional Offices through enhanced-use leases:

Location	Activation Date	Amount	Purpose
Chicago	FY 2003	$472,000 [GOE] ..	Move from leased GSA space into a new enhanced-use facility. The funds will be used for security equipment, LAN electronics, shipment of files, and equipment to the new location.
Milwaukee	FY 2003	$471,000 [GOE] ..	Move from a 120-year-old VA Regional Office into a new enhanced-use facility. The funds will be used for security equipment, LAN electronics, shipment of files, and equipment to the new location.
Los Angeles ...	FY 2004	$3,000 [GOE]	Move from a GSA leased facility into a new enhanced-use facility. The funds will be used for the groundbreaking ceremony.
Indianapolis ...	FY 2005	$1,000,000 [Minor].	Move from leased GSA space into new enhanced-use facility. The funds will be applied towards the purchase of furniture, the telephone switch, and LAN electronics for the new facility.
Nashville	FY 2005	$1,000,000 [Minor].	Move from leased GSA space into a new enhanced-use facility. The funds will be applied towards the purchase of furniture, the telephone switch, and LAN electronics for the new facility.
Buffalo	FY 2003	$1,331,000	Move into another GSA facility. Existing GSA building is asbestos contaminated and not large enough to support station operations. Funding is for security equipment, LAN electronics, guard service, and shipment of files and equipment to new location.
Louisville	FY 2003	$1,357,000	Move to another GSA facility. Lease is expiring and facilities are inadequate. Funding is for security equipment, LAN electronics, guard service, and the shipment of files and equipment to new location.
Phoenix	FY 2003	$3,189,000	Move to VA-leased facility. Current GSA? leased facility is inadequate in both size and quality. Funding is requested for security equipment, LAN electronics, furniture, guard service, and shipment of files and equipment to new location.

The FY 2003 Budget request supports relocating the following VA Offices:

Location	Activation Date	Amount	Purpose
Las Vegas	FY 2003	$72,000	Relocated from temporary trailers to a new co? located Enhanced Use facility. Funding is for guard service and shipment of files and equipment to new location.
Sacramento	FY 2003	$520,000	Move from GSA-leased to new VA-leased facility. VBA will be shifting workload from the more expensive Oakland area to Sacramento. The existing Sacramento lease expires and the current building cannot support the planned expanded operations. Funding is for security equipment, LAN electronics, furniture, and shipment of files and equipment to new location.

Question 29a. Your budget assumes that the vendee loan program will be terminated administratively. What savings are you projecting and where are the savings being redirected?

Answer. The VA estimates that 22 FTE ($1.4 million) will be saved in administrative funding by eliminating vendee financing in FY 2003. However, this funding was removed from the base recognizing savings from this action.

Question 29b. What is the basis for assuming that there will be savings from the elimination of the vendee loan program when VA's study from Booz Allen found that properties sold with vendee loans "achieve a higher net value to VA than do properties sold for cash."

Answer. Vendee loans extend the government's liability for many years. By selling all properties on a cash basis, future expenses due to foreclosure of vendee loans will be eliminated.

Question 29c. Assuming the vendee loan program were eliminated, have you considered the impact of a declining economy which would boost inventory or reduced flexibility on financing which could result in lower selling prices?

Answer. We believe that there is sufficient private mortgage financing available to allow VA to sell all properties for cash without a build up of inventory.

Question 29d. Your budget assumes the administrative elimination of the vendee loan program, after years of requesting legislation to implement this proposal. What is the basis for the change in the assumption that this action required legislation?

Answer. Public Law 98–369, enacted on July 18, 1984, specified both a minimum and maximum percentage of sales of VA-owned properties that had to be sold with vendee financing. Public Law 102–54, effective October 1, 1990, repealed those percentage limitations. Since that date, the Secretary has the authority to sell acquired properties on terms the Secretary determined appropriate. Elimination of vendee financing would be a significant change. Therefore the Department requested that Congress consider whether this should be a legal restriction on the Secretary's authority.

Question 29e. Does the elimination of the vendee loan program affect the A–76 study on VA Loan Guaranty property management?

Answer. The elimination of vendee financing will have no significant impact on the outcome of the A–76 cost comparison.

Question 30. What is the status of the A–76 study on VA Loan Guaranty property management?

Answer. VA's Property Management A–76 Cost Comparison Study is in the solicitation phase. The deadline for the receipt of the proposals was October 3, 2001. The evaluation of the private proposals was completed in late January 2002. Currently, we are projecting a tentative decision on the winner of the competition in April or May of 2002. Meeting this milestone will depend upon completing the final evaluation, making any necessary modifications to the Government's bid, and conducting an independent review.

Question 31. In 1998, Congress created a pilot project designed to increase the availability of transitional housing for homeless veterans. To date, no loans have been approved and disbursed. Please provide detailed information on the status of the program and describe the reasons it has not been put in place.

Answer. The Loan Guaranty for Multifamily Transitional Housing for Homeless Veterans was established under Public Law 105–368, "Veterans Benefits Enhancement Act of 1998." This program is to provide large-scale transitional housing for homeless veterans. The law authorizes VA to establish a pilot program to guarantee no more than 15 loans with an aggregate value of $100 million for construction, renovation of existing property, land, refinancing of existing loans, facility furnishing and working capital. By law, the loan cannot exceed 90 percent of costs. It is hoped that up to 5,000 transitional housing units will be created using this initiative.

Eligible transitional projects are those that: (1) provide supportive services, including job counseling; (2) require veterans to seek and maintain employment; (3) require veterans to pay reasonable rent; (4) require sobriety as a condition of occupancy; and (5) serve other veterans in need of housing or other homeless people on a space available basis.

In determining whether to guarantee each loan, the Secretary of Veterans Affairs must consider the availability of VA medical services to residents of the housing project and the extent to which a variety of needs of homeless veterans are met in a community.

This new initiative requires significant collaboration among VA offices, including: the Veterans Benefits Administration's Loan Guaranty Division; VHA's Office of Facilities Management; VA's Office of Acquisition and Materiel Management and Office of General Counsel; Office of Public and Intergovernmental Affairs; and other offices.

As mandated by law, VA entered into a contract with the consulting firm, Birch and Davis Associates, in January 2000. Birch and Davis Associates, in turn subcontracted with Century Housing Corporation, Culver City, CA, for their expertise in financing and development of transitional housing for homeless veterans. The role of the contractor is to assist in designing a guarantee program.

VA has held numerous meetings with the contractor reviewing their work and suggesting modifications consistent with the goals established by the Congress. The unique nature of this program has meant that we have proceeded with great care trying to balance our fiduciary responsibilities for this program, as well as trying to ensure the needed supportive services will exist to aid those veterans in their transition.

This Department remains hopeful that this complicated review is near completion. It is anticipated that this program will become available, to a limited number of

sites later this year, and that we may have one or more proposals that may be reviewed and approved next year.

Question 32a. In 2000, Congress passed significant enhancements to the GI Bill—increasing the basic monthly benefit, paying for licensure and certification exams, and covering the remaining costs of service members' courses after payment from DOD's tuition assistance. Your projections last year predicted that these provisions would double the workload of the education service, adding further stress on top of some recent increases in your backlog due to the imaging of claims at one of your four processing centers. In 2001, Congress again, expanded and increased educational benefits. What are your workload projections from the new changes?

Answer. In 2001, we made payments to 421,078 eligible individuals under the various GI Bill education programs, a six percent increase over the previous year. The 500,000 beneficiaries we expected to serve did not materialize, primarily because claims for the new programs did not begin arriving until March and April. The pace of incoming work increased as FY 2002 began. If it continues, more than 600,000 beneficiaries will seek GI Bill benefits this year.

Question 32b. What are your plans to address increased claims?

Answer. In anticipation of the increased workload, VA hired over 100 new employees to handle education claims. Because incoming work was less than expected, we were able to reduce the backlog and provide the new employees adequate training. Those employees are becoming more proficient with each passing day. As 2002 progresses, we expect the staff we have hired and trained to be able to process the anticipated workload.

Question 32c. What are you doing to decrease the current backlog of education claims, particularly at the time of fall enrollment?

Answer. When compared to the prior year, performance improved significantly during the most recent fall enrollment (August through October 2001). Claims were processed more timely during that period and output improved by more than ten percent. Several actions contributed to this improved performance. First, adequate overtime was authorized earlier in the fall and was focused on achieving production targets. Second, seasonal employees were hired to perform certain tasks during peak periods, allowing station managers to shift their experienced staff to areas in claims processing. Third, the new employees gained experience throughout the period, resulting in increased per capita output. We will continue to appropriately target our overtime and use seasonal employees during peak enrollment cycles to effectively manage our workload.

Question 33a. This budget request includes a proposal to shift the Veterans Employment Training Service grant programs to VA and convert them to a competitive grant. What short-term and long-term effects will the proposed transfer of employment and training services have on veterans? How will you prevent a gap in service for veterans using these programs?

Answer. Because of the lead-time required to implement grants, VA plans to keep the Department of Labor (DOL) funded grants in place during the first year after transfer. DOL staff transferring to the VA will bring with them the requisite expertise and familiarity to effectively continue the Disabled Veterans Outreach Program (DVOP) and Local Veterans Employment Representative (LVER) program grants thus ensuring no degradation of service to veterans during the initial transition year.

Because the current DOL grants are staffing grants, continuity of the existing programs during the first year after transfer is also important to DOL's ability to maintain current services level in FY 2002.

In succeeding years, changing the federally funded employment and training program non-competitive, staffing grants to competitive, performance-based grants will have the positive effect of both increasing the number of veterans who are served and improving the service effectiveness resulting in more veterans obtaining employment as a result of these services.

Regarding the Homeless Veterans' Reintegration Program (HVRP), VA's relationship with DOL's grantees under HVRP has been good, however, the proposed transfer will allow VA to improve coordination with the employment programs. This enhanced relationship should help to ensure that the expensive and extensive health care services VA provides to tens of thousands of veterans will have enhanced opportunities to succeed by obtaining and retaining employment with a more collaborative program design.

VA and DOL are in the process of developing a program transition plan that will keep the DOL funded DVOP, LVER and HVRP grants in place during the first year after transfer. This should ensure continuity of service.

Regarding HVRP, veterans who have been homeless and are discharged from VA programs will be in better position to succeed since the effort will allow us as the

funding source to demand collaborative efforts to assist those hardest to serve veterans.

Question 33b. The VA is already facing many of its own challenges, including a significant claims backlog and a new focus on employment in the Vocational Rehabilitation and Employment program. How is the VA, having little job placement expertise equipped to administer these programs at this time?

Answer. VA has extensive experience in grant administration. The immediate tasks facing the VA are designing a new program that is significantly more cost-effective and to organize an employment, business opportunity and training office within VA that will provide effective oversight of the grant program. Effective oversight of performance-based, competitive grants is critical to VA's efforts to transform veterans' employment programs. VA expects that the DOL federal staff who transfer to VA when the program transfers will bring their expertise to support administration of the program at VA.

Question 33c. What was the basis for determining that VA was better equipped than the Department of Labor to provide employment and training services? What outside entities, if any, was consulted in developing this proposal?

Answer. It is clear that the DVOP and LVER programs have not served veterans' job search assistance needs well for a long time. The Commission on Servicemembers and Veterans Transition Assistance (Commission) report and at least six GAO reports issued in the past five years extensively document long-standing shortfalls with the DVOP and LVER programs. In spite of the public awareness that these two programs, as currently administered, are falling far short of the excellence we should demand of programs so important to many veterans' ability to enjoy the secure and productive life that their service defended for all Americans, change to the programs has not occurred.

While VA can much more easily step "outside the box" when evaluating veterans' employment assistance needs and develop a program that better meets the needs of today's veterans and ensures adequate flexibility in design to allow for adapting to the needs of tomorrow's veterans.

Specifically pertaining to HVRP, VA expects to expand upon what we believe have been highly successful partnering with states, local governments, Native American Tribal governments, faith-based and non-profit organizations under the State Cemetery, State Home and Homeless Service Providers Grant and Per Diem Program.

To ensure that the VA program is able to provide optimal job search services to veterans VA is informally consulting with veterans' representatives, employers, governors, and service providers regarding:

- What employment and training services do America's veterans of the 21st Century need most?
- What is the most cost-effective way to provide these services?
- How can the new program better meet the needs of employers?

Question 33d. Were smaller-scale modifications to the program considered, such as a pilot competitive grant program?

Answer. As mentioned earlier, the shortfalls of the DVOP and LVER programs are so extensive that marginal changes will not produce the degree of change essential for meeting the job search assistance needs of today's veterans and effectively linking employers in the global economy with highly qualified veteran job applicants.

VA intends to work with Governors to ensure that veterans in every state have equal access to high quality core services regardless of where they live or where they want to work. VA is considering an option to seek legislative authority to reserve up to 25 percent of the total available funding for competitive grants to finance pilot programs and demonstration projects of innovative service types and delivery systems. Successful pilot projects will be incorporated into flexible national baseline service delivery systems.

Question 33e. How does VA plan on partnering with the Department of Labor to ensure that veterans are getting access to all appropriate employment programs?

Answer. As pointed out in the Commission's 1999 report, a close working relationship between VA, DOL and the Department of Defense (DOD) is essential for ensuring seamless job search assistance and training, particularly for recently separated veterans. The more successful we are in ensuring that the highly trained and motivated separating service members are able to secure employment that leads to a successful career the less likely they will become dependent on our services later in life.

VA looks forward to developing a long and mature relationship with DOL at both the administrative and policy levels. VA expects that the requirement that veterans will receive priority in all DOL funded employment programs will continue as national policy. VA intends to meet shortly with DOL's Employment and Training Ad-

ministration (ETA) to discuss the most cost-effective way for VA to link its employment program to the several electronic labor market systems funded by ETA. VA anticipates that in the future, as necessary, issues of national employment policy as they affect veterans will be addressed at the Cabinet level thus adding the weight of two Secretaries to any ensuing policy decisions.

Question 33f. One of the criticisms of the program at the Department of Labor has been a lack of accurate performance measures. If the Administration's plan is implemented, how will the shift to VA affect performance and cost-effectiveness measurement?

Answer. There are two essential components directly affecting grantee performance. First, VA intends to set clear, obtainable and easily measured outcome performance standards. Measures such as the number of veterans who obtain a job and duration of employment are examples of such outcome measures.

Second, there must be something at risk for the grantees in order for VA's grant oversight to be effective. Simply stated-rewards for exceptionally high performance and a cost for failing to deliver agreed upon outcomes. Quite frankly, a new grant program that is not competitive in nature can only fare marginally better than the existing programs. This is not to suggest that the competition must be at the national level, competition within states can be just as effective.

As to the HVRP, employment has always been a measure of success for veterans who have been homeless. Without health care, housing and employment the likelihood of long term success for the veteran is greatly handicapped. While VA has done a creditable job in responding to the health care needs, housing and employment are largely outside of VA's direct efforts. While our homeless veterans grant and per them program has greatly aided the need for housing with supportive services, the longer term need of employment and independent living has largely been outside of our direct line of responsibility.

Combining the health care, housing and employment outcomes for homeless veterans will enhance VA's opportunities to effectively monitor not only costs, but also the long-term values of each.

Question 33g. This budget basically asks for level funding for the VETS program. Without increased resources for improving this program, does the Administration seek to merely transfer the current program to a different agency? How does VA know that this budget request for the transfer is adequate without a specific implementation design? How does VA plan to administer the new competitive grant program without additional FTEs?

Answer. As discussed in an earlier answer, because of the lead-time required to implement grants, VA has little choice but to keep the Department of Labor (DOL) funded grants in place during the first year after transfer. Thus, program costs should remain constant for the first year—FY 2003.

In the long term, there would be no advantage to merely transfer the grant programs from DOL to VA. The Administration acknowledges that the DVOP and LVER programs have not served our nation's veterans well for a long time as evidenced by DOL's report that the national average percentage of registered veterans between the ages 22–44 who were placed in a job steadily declined from an unacceptable low of 16 percent in PY 1997 to an unbelievable 12 percent in PY 2000. This performance, during a period of historically low unemployment, simply cannot continue.

Through this initiative, the Administration seeks to redesign and reenergize our national job search assistance services in such a way as to ensure that all veterans and eligible service members have equal access to the services they need to secure employment regardless of where they live or are stationed. VA believes that this goal can be accomplished, without substantial increases in funding, by connecting things (technology, systems and service providers) that exist presently and managing them in a way that transforms our national employment service delivery system for veterans.

VA intends to ensure that the design of the new grant program will focus available resources and effort at the veteran in need of services and employers, not on bureaucracy. Quantifiable results rather than status quo will be our measuring stick.

As stated above, because of the lead-time required to implement grants, VA intends to keep the Department of Labor (DOL) funded grants in place during the first year after transfer. Thus, program costs should remain constant for the first year.

VA believes that the 199 DOL FTE projected to-transfer with the program are adequate to administer the grant program at VA.

Question 33h. Will the Administration's plan include outreach to help current state employees working for existing grant recipients meet requirements to apply for the new competitive grants?

Answer. It is in everyone's best interest, but most certainly the veterans seeking assistance and employers looking for good applicants, that highly qualified service providers seek and are awarded service grants. VA is committed to do everything possible to ensure that it happens. It seems logical that where the current grantee (State Employment Security Agency) is performing well that they will be competitive when seeking future veterans grants.

The first year after transfer VA will continue all existing DOL funded grants. VA is considering a program structure that would award new grants (replacing the DVOP & LVER grants) to the Governors in the second year with the requirement that the States sub-award competitive grants or contracts to service providers. The VA awarded State grants will include provisions requiring the States to conduct "bidders conferences" intended to assist potential offerors to understand the new program service requirements and better enable them to be fully responsive to the State's solicitation for grant applications (SGA). Additionally, VA will consider conducting a national forum to communicate program changes and expectations directly to interested potential service providers.

Question 34a. The Employment Specialist pilot program within the Vocational Rehabilitation and Employment program has improved disabled veterans placement numbers, but in order to broaden its reach, VA will require personnel with specialized expertise in employment markets and job markets. How will VA recruit such personnel? Does your budget request of 15 additional FTEs cover needed specialists?

Answer. The Employment Specialist Pilot Program has proven to be highly successful. We recruited nearly 40 Employment Specialists to help us more rapidly shift the focus of the Vocational Rehabilitation and Employment Program to employment. We believe that the request for 15 FTE in 2003, along with the flexibility provided by the transfer of funds from the Readjustment Benefits account to the General Operating Expense account, provides opportunities for further realignment of the staff and recruitment of additional Employment Specialists. The Employment Specialist Pilot Program helped us identify the skills sets needed to focus on marketing and placement of people with disabilities and made it easier to find individuals to fill this gap.

Question 34b. Improving outcome-based performance measures of the VR&E program is needed to determine why a significant percentage of program participants eventually drop out. However, VA states in the budget that this cannot be accomplished until Corporate WINRS is fully implemented. What is the status of Corporate WINRS and does VA have the funding necessary to support rapid development?

Answer. To gain a better understanding of why people leave the program without a successful outcome, we asked our in-house rehabilitation staff to identify the reasons based on their experiences. Through this in-house survey, we identified the top five reasons why veterans leave the program. We validated this information through a third-party study. The top five reasons for participants leaving the program are:

Medical reasons
Family responsibilities
Financial issues
Participant took a job
Disabilities

Since the time of this study, we have developed a number of strategies (e.g., Case Management, Corporate WINIRS, the Employment Specialist Pilot Program) that will help us better assist participants who are at-risk for leaving the program due to these or other reasons. While we believe that any veteran leaving the program without a positive outcome is a lost opportunity, we are pleased to report that the rehabilitation rate last year was 65 percent, the highest in the program's history. Conversely, our drop out rate was the lowest in the program's history.

In September 2001, VBA nationally deployed Phase I of Corporate WINRS. This represented the first phase of a multi-year information technology initiative. Our FY 2002 funds will permit us to develop and deploy new enhancements that will enable us to extract data to conduct a myriad of analyses to include the characteristics of veterans leaving the program. With approval of future funding, we expect to continue to increase the functionality of Corporate WINIRS to support future program strategies and build on our capacity to collect meaningful program data about disabled veterans who participate in the VR&E program.

INFORMATION TECHNOLOGY

Question 35. Is VA running into any unforeseen problems in implementing the One-VA Enterprise Architecture?

Answer. No. The One-VA Enterprise Architecture has been embraced across the Department. While there remains a great deal to be done to develop this architecture, remarkable progress has been made in a very short period of time, given that full funding for Enterprise Architecture will not begin until FY 2003.

The following progress has been made between October 2001 and February 2002, in developing the Enterprise Architecture:

- The Department of Veterans Affairs "Enterprise Architecture: Strategy, Governance & Implementation" was approved in September 2001.
- The Information Technology Board (1713), which is a critical element of the Enterprise Architecture Governance, was established in October 2001.
- VA's ITB has chartered an Enterprise Architecture Council (EAC), and an Enterprise Architecture Working Group has been established.
- An Acting Chief Architect has been appointed; we are in the process of establishing and recruiting for a VA Chief Architect (SES level); and a program-staffing plan has been developed.
- The top-level definition of the VA functional enterprise has been completed.
- A technical model for the implementation of new IT projects has been defined.
- A comprehensive change in how we oversee the management of our IT Projects has recently been approved. This new oversight process will ensure that all new IT projects are developed in compliance with the Enterprise Architecture.
- Two prototype applications are being developed to integrate the Enterprise Architecture and VA's new IT Management Process. Both applications are paperless and intranet-accessible. The current proof-of-concept prototype implementation is functional on the VA-Intranet and was presented to GAO on January 30, 2002. This implementation will be followed by a more robust and extensive implementation when FY2003 funding is received.

For the remainder of FY2002, using in house resources:

- The EAC will undertake a preliminary analysis of the requirements, business functions and business processes and complete the initial functional allocation of VA's business functions this summer. This is a major, long-term effort involving both business and technical leadership across VA.

Question 36. Has VA effectively instituted a central review process to guard against individualized and non-compatible technology investments, which may not fit into VA's strategic plan?

Answer. VA has instituted a new process that integrates IT project planning, budgeting, Enterprise Architecture, Project Management Oversight and project execution. This new process is applied to all investments in information technology. The process includes periodic senior management reviews to determine how well a project is performing. These senior management reviews approve project initiation, approve proceeding with a prototype or pilot, approve proceeding to full-scale development based on the results of the prototype, approve project deployment, and review in-service performance. At each of these reviews the project manager must demonstrate that the project meets objectives of the VA Strategic Plan, is not duplicative, and meets the requirements of the Enterprise Architecture from both a business and technical perspective. Adherence to the standards will cause compatibility issues to be sharply reduced. In addition, we have implemented a tracking system to ensure that all funds expended on IT meet the requirements of only approved projects.

Question 37. VA has been criticized by its Inspector General and GAO for failing to ensure data confidentiality and allowing vulnerabilities within its information technology systems. It is clear that VA must rapidly implement initiatives to secure mission-critical systems and beneficiary data. There is not enough specific discussion of VA's long-term cyber security plans in the budget submission. Is this really a priority, and does the proposed budget provide sufficient funds to cover these needs?

Answer. The protection of the Department of Veterans Affairs' information assets is a top priority, and through continued senior management attention, we can institute effective computer security.

During the past year, the Department has made significant progress in institutionalizing IT security as a priority issue. In March 2001, the Office of Cyber Security (OCS) was established to serve as the much-needed focal point for leveraging existing resources and implementing security initiatives on a global basis within the Department. In August, the Secretary appointed the Department's first Chief Information Officer, who also serves as the Assistant Secretary for Information and Tech-

nology. In September, the Department completed its first ever cyber security program review under the provisions of the Government Information Security Reform Act.

In December, OCS, in conjunction with VA components, requested the advice of the VA OIG in determining those key deficiencies that should take immediate precedence for remediation in order to maximize resources and make the most significant improvement in the Department's overall security posture in the near term (next twelve months). Discussions with the OIG identified "key weakness areas" that were deemed to require priority action. These weakness areas included fielding Department-wide intrusion detection system and anti-virus capabilities; integrating critical infrastructure protection into IT security planning; updating and testing disaster recovery plans at VA Data Centers; upgrading security features on VA Internet Gateways; and remediating deficiencies relating to the areas of application software development, change controls, and system software controls.

With the above priorities in mind, we have made substantial progress in correcting these weaknesses. In FY2003, we will have a Department wide, integrated cyber security execution plan that optimizes and prioritizes the expenditure of all Department and Administration Cyber Security funding to continue correcting these weaknesses. As the integrated FY2003 execution plan is being developed, we will determine the levels of funding necessary in FY2004 and beyond to complete the job of removing all cyber security material weaknesses and institutionalizing cyber security as a critical element in each of our IT projects.

FRANCHISE FUND ENTERPRISE CENTERS

Question 38. Have the Franchise Fund Enterprise Centers been able to successfully market services to other Federal agencies? Please provide specific customers and describe efforts to reach new government customers.

Answer. Most of our customers come from within VA—which accounts for 94.5 percent ($141.8 million) of our FY 2001 revenue. The individual Enterprise Centers have encountered varied success in their ability to attract outside business. In FY 2001, 5.5 percent ($8.2 million) of our revenue came from cross servicing arrangements with Other Government Agencies (OGAs). In FY 2001, the Austin Automation Center accounted for most of this OGA revenue, i.e., $6.7 million. We estimate that our FY 2002 revenue will be approximately $148 million ($140 million from VA business and $8 million for OGA).

We have made significant enhancements to the Enterprise Center Websites and to our marketing materials, e.g., corporate brochures. Website enhancements include compliance with Federal Government standards and the incorporation of a common navigation scheme with links to each other. Our corporate brochure vividly conveys the product offerings of our Enterprise Centers. In addition, the Enterprise Centers exhibit and speak at various conferences that attract Federal agencies (Association of Government Accountants Professional Development Conference, Excellence in Government Conference, E-Gov Conference, FOSE Conference, etc).

Website URLs

Enterprise Fund Office—*http://www.va.gov/fund*
Austin Automation Center—*http://www.aac.va.gov*
Debt Management Center—*http://www.va.gov/debtman*
Financial Services Center—*http://www.fsc.va.gov*
Law Enforcement Training Center—*http://www.va.gov/osle/valetc*
Security and Investigations Center—*http://www.va.gov/sic*
VA Records Center and Vault—*http://www.va.gov/vault*

Specific Customers

Enterprise Center	Other Federal Customers
Austin Automation Center	Department of Commerce
	Departments of Defense
	Department of Labor
	Department of Justice
	Department of the Treasury
	Federal Highway Administration
	Federal Energy Rate Commission
	General Accounting Office
	General Services Administration
	National Aeronautics and Space Administration
	National Archives and Records Administration
	National Oceanic & Atmospheric Administration
	Office of Federal Housing Enterprise Oversight
	U.S. Army Medical Command
Debt Management Center	Department of Agriculture
	Drug Enforcement Administration
	Federal Bureau of Investigation
	Immigration and Naturalization Service
	Minnesota Cooperative Administrative Support Unit
Financial Services Center	Department of the Interior
	Federal Energy Regulatory Commission
	Immigrant Health Services
	Indian Health Services
	Office of Federal Housing Enterprise Oversight
	U.S. Mint
	U.S. Naval Home
Law Enforcement Training Center	Indian Health Service
	National Guard
	National Museum of Art
	Walter Reed Army Medical Center
	Washington Navy Yard
Security and Investigations Center	Export/Import Bank
	Office of Federal Housing Enterprise Oversight
	Office of Occupational Safety Health Review Commission
	National Council on Disability
VA Records Center and Vault	Defense Finance and Accounting Services (DFAS)
	DFAS—Cleveland (Navy)
	DFAS—Indianapolis (Army)
	Defense Technical Information Center
	Department of Energy
	Postal Rate Commission

VETSNET

Question 39. The VA Claims Processing Task Force recommended that VA take a close look at the viability of VETSNET, an 8-year-old enterprise solution project that is still not operational. The Task Force implementation team has determined that VETSNET is a necessary stepping stone to migrating to new technologies that allow greater interoperability and seamless data access. Have other system solutions been sufficiently demonstrated? What is VA's long-term replacement strategy for VETSNET?

Answer. In accordance with the VA Capital Investment process, VA identified a total of five alternatives and conducted a comprehensive analysis of each before choosing the VETSNET approach. The five alternatives are (1) upgrading the Benefits Delivery Network, (2) continue designing and developing a custom built system, (3) outsource or obtain cross-servicing for at least some of the VETSNET processes, (4) acquiring COTS software and (5) a combination of custom building and COTS. After an extensive analysis of these alternatives, VA chose to continue designing and developing a custom built system—i.e., VETSNET.

VA has identified a three-phased approach to support a redesigned and integrated claims process. The three-phased approach includes (1) determining viability, (2) internally implementing an integrated claims process, and (3) addressing the strategic plans of VA in regard to integrating the claims process.

VA's Enterprise Architecture (EA) is the blueprint for systematically and completely defining and documenting the organization's current (baseline) and desired (target) environment, and includes a sequencing plan for transitioning from the baseline environment to the target environment.

VA's Enterprise Architecture strategy is essential for evolving VA information systems such as VETSNET. Therefore, as an initial step, VETSNET application development will be continued in the VETSNET architecture and integrated into the VA Enterprise Architecture. As the next step, VA will conduct studies leading to the development of an integrated claims process, which will determine the precise manner of the VETSNET "replacement" for the long-term.

OFFICE OF INSPECTOR GENERAL

Question 40. The Office of Inspector General (OIG) is tasked with increasing internal audits, investigations and inspections, but this budget does not include an increase in the OIG FTE's or any significant increase, outside of personal services. How can the OIG effectively meet the goals set forth in the budget documents without additional resources?

Answer. The VA recognizes that the record-setting accomplishments of the VA OIG during the past few years clearly demonstrate the cost effectiveness and value added from an investment in the OIG. The final numbers for FY 2001 were even higher than expected. The OIG identified over $4 billion in funds put to better use, for a return on investment of $86 to $1. They also recovered $33.7 million in fines, penalties, restitutions and civil judgments in FY 2001, and generated contract audit hard dollar returns in excess of $42 million that went directly back to VA during the past year alone. As impressive as these numbers are, they do not capture other important performance results. The OIG achieved a 300 percent increase in investigative actions since 1998. This performance includes a 34 percent increase in indictments in 2001 and the successful conclusion of high profile cases that led to the conviction of two serial killers who murdered veterans.

For 2002, the OIG received a $6 million or 13 percent increase over the previous year's funding level. The 2003 request provides an additional $2.7 million (excluding CSRS and FEHB funds). The request is consistent with the level of performance the OIG expects to achieve in 2003. The strategic targets represent the ideal level of performance that each VA organization—including the OIG—is striving to accomplish.

OFFICE OF GENERAL COUNSEL

Question 41a. The budget request for the Office of General Counsel (OGC) cites that the funding level will enable OGC to continue to meet the increasing demand for legal services by the VA, while still managing its representation responsibilities at the U.S. Court of Appeals for Veterans Claims (CAVC). Please provide a breakdown of the type and volume of work that OGC is performing.

Answer. The Office of General Counsel (OGC) provides legal advice and representation to the Secretary and subordinate managers in VA headquarters and field locations. In the field, twenty-three Regional Counsels and their staffs provide such legal advice and representation. Six Assistant General Counsels and their staffs act on behalf of headquarters managers. The following charts in spreadsheet format provide the numbers of cases that OGC field attorneys are responsible for or have completed during the current fiscal year (October 2001 through January 2002), arranged by subject matter categories.

Combined Workload Summary for Regional Counsel Offices (Chart 1)—The Regional Counsel Offices provide comprehensive legal services to Veterans Health Administration (VHA), Veterans Benefit Administration (VBA) and National Cemetery Administration (NCA) managers throughout the United States and in Puerto Rico. The major subjects (minus Medical Care Cost Recovery) for which Regional Counsel provide advice and representation are represented on Chart 1.

CHART 1.—COMBINED WORKLOAD SUMMARY FOR REGIONAL COUNSEL OFFICES

NATIONWIDE [thru January 2002]	ADMIN PENDING	ADMIN COMPLETED	LIT PENDING	LIT COMPLETED	TOTAL PENDING	TOTAL COMPLETED	TOTAL WORKLOAD
1 Medical Malpractice	1,989	352	527	100	2,516	452	2,968
2 Personal Injury	327	84	86	16	413	100	513
3 Property Damage	398	205	12	2	410	207	617
4 FMCRA	5,953	1,199	91	9	6,044	1,208	7,252
5 Workers Compensation	2,558	615	18	1	2,576	616	3,192

CHART 1.—COMBINED WORKLOAD SUMMARY FOR REGIONAL COUNSEL OFFICES—Continued

NATIONWIDE [thru January 2002]	ADMIN PENDING	ADMIN COMPLETED	LIT PENDING	LIT COMPLETED	TOTAL PENDING	TOTAL COMPLETED	TOTAL WORKLOAD
6 Health Insurance	232,346	5,415	263,388	1,455	495,734	6,870	502,604
7 Category C (Co-Payment)	191	17	26	7	217	24	241
8 Ineligible/Humanitarian	51	0	5	0	56	0	56
9 Auto Reparations	827	337	2	0	829	337	1,166
10 Crime Victims Act	3	0	0	0	3	0	3
11 Debt Collection	205	52	68	28	273	80	353
12 Bankruptcy	2,115	2,564	872	306	2,987	2,870	5,857
13 Escheat/General Post Fund	145	48	3	0	148	48	196
14 Probate Claims	1,158	441	37	14	1,195	455	1,650
15 VA Rroperty Damage	44	8	1	0	45	8	53
16 Other Recoveries	197	155	21	3	218	158	376
17 Commitment	599	100	12	40	611	140	751
18 Guardianship	599	831	162	176	761	1,007	1,768
19 VA Benefits	0	134	9	9	134	143	
20 Contracts	327	371	14	0	341	371	712
21 VABCA	6	1	0	0	6	1	7
22 Personnel Actions	2,236	614	355	45	2,591	659	3,250
23 Law Enforcement	80	33	7	1	87	34	121
24 MPCE Claims	113	62	1	0	114	62	176
25 Loan Guaranty Actions0	0	0	0	0	0	0	
a. Acquisitions	1,406	6,300	108	13	1,514	6,313	7,827
b. Assumption Agreements	3	9	0	0	3	9	12
c. Evictions	560	501	81	67	641	568	1,209
d. Mortgage Releases	53	58	0	0	53	58	111
e. Sale Of VA Loans	90	629	1	0	91	629	720
f. Sales VA Properties	398	1,789	7	3	405	1,792	2,197
g. Multi-Units	29	97	0	0	29	97	126
h. Other Loan Guaranty	823	1,351	77	49	900	1,400	2,300
26 Written Opinions	196	203	0	0	196	203	399
27 Other Cases	3,793	7,797	101	63	3,894	7,860	11,754
Total	.....	.....	.....	.....	30,176	27,900	58,076

Combined Medical Care Cost Recovery Statistics for the Office of General Counsel (Chart 2)—The Regional Counsel Offices and Professional Staff Group I advise VHA managers concerning the collection of monies due VA from insurance carriers, tortfeasors, worker's compensation insurance carriers and others. These entities owe monies to VHA for care provided veterans (or others on a humanitarian basis) at VA medical centers on a partially or fully reimbursable basis.

CHART 2.—COMBINED MEDICAL CARE COST RECOVERY

Nationwide [thru January 2002]	
FMCRA	$2,721,745.50
Workers Compensation	1,094,025.52
Health Insurance	918,117.00
Category C (Co-Payment)	2,350.70
Ineligible/Humanitarian	25.00
Auto Reparations	291,617.89
Crime Victims Act	995.38
Debt Collection	52,782.09
Bankruptcy	134,722.15
Escheat/General Post Fund	285,375.57
Probate Claims	1,334,287.
VA Property Damage	14,160.95
Other Recoveries	514,016.89
Total	7,364,221.67

Information regarding Professional Staff Group VII's workload is provided in the answer below. OGC does not currently have a reliable method for capturing the complete workloads of its other headquarters elements. Recognizing the problem,

OGC is now field-testing a new computer-based workload-reporting system that will accurately capture the varied administrative, legal and representational activities performed by the attorneys at VA headquarters. OGC will be able to report reliably on its workload in the near future.

Question 41b. What is the current caseload of Group VII before the CAVC?

Answer. There were 1,822 cases pending as of January 31, 2002.

Group VII is responsible for preparing the record and submitting the proper pleadings in all appeals filed in the CAVC. In addition, Group VII is responsible for answering petitions for extraordinary relief under the All Writs Act filed with the Court, and answering all applications for attorney fees under the Equal Access to Justice Act filed with the Court.

In fiscal year 2001, there were 3,521 new cases filed with the Court, comprised of 2,203 appeals, 105 petitions for extraordinary relief, and 1,213 applications for attorney fees. On top of these new cases, when the fiscal year commenced in October 2000, there were 2,580 cases carried over as pending from the previous fiscal year. The Court closed 4,118 cases during the year.

In the first one-third of fiscal year 2002 (October 1, 2001 through January 31, 2002), there were 795 new cases filed with the CAVC, comprised of 548 appeals, 67 petitions for extraordinary relief, and 180 applications for attorney fees. There were 1,982 cases carried over as pending from the preceding fiscal year. The Court closed 955 cases in the first four months of fiscal year 2002. Hence, there were 1,822 cases pending as of January 31, 2002.

Question 41c. Veterans issues are a very limited specialty. When veteran's cases are appealed from the CAVC to the U.S. Court of Appeals for the Federal Circuit, Department of Justice attorneys represent the government. However, VA cases are a smaller part of their caseload. What is your opinion of the VA representing the government in these cases at the Federal Circuit?

Answer. Because cases involving VA benefit claims are heard only in the CAVC and in the Federal Circuit, those two courts have most affected the development of case law governing veterans' benefits. The Federal Circuit in particular has been taking an increasingly active role in formulating that law. It has issued many precedential decisions during the past year with far-reaching and fundamental effect on VA's processing of claims. For that reason, it is important that VA's position in litigation, including all the background information necessary to put the position into context, be presented to the Federal Circuit as fully and persuasively as possible.

VA administers many programs established by law for the benefit of veterans, their dependents, and their survivors. The claim process is extensive and complicated. Consequently, it takes a number of years of working with the system to develop familiarity with, and expertise in, the system.

VA attorneys can provide valuable assistance throughout all stages of appellate litigation involving veterans' benefits especially at oral arguments because of their familiarity with VA regulations and procedures and their detailed knowledge of the intricacies of the VA adjudication system. As VA has opened a discussion with DOJ on this issue, and we intend to work with DOJ to continually improve United States' representation in the Federal Circuit.

BOARD OF VETERANS' APPEALS

Question 42a. Now that the regulations to implement the direction to the Board of Veterans' Appeals (BVA) to develop claims that lack some key piece of evidence are in place: How is the BVA implementing this new activity?

Answer. The Board restructured to provide dedicated BVA assets for case development. Our efforts have been coordinated with the Veterans Benefits Administration (VBA) which will provide co-located adjudicators for benefit awards. BVA has authority to begin developing cases as of February 25, 2002. Initial receipt and processing of appeals will continue as before. When a decision team reviews a case and determines that a decision cannot be entered without additional evidence, a team member will prepare a development order setting out the development required (in the past this would have been a remand decision). The case is then forwarded to the Board's Development Team which will obtain the needed information. (Individuals comprising this team had 30 days of classroom training with a VBA trainer and 30 days of hands-on training developing cases at the Washington regional office.) BVA has been given access to VBA and VHA systems development software. These programs have been installed and/or enhanced to permit development to be accomplished effectively and efficiently at the Board. When all requested development has been completed and information received by the Board, the case will be returned to the decision team for review and preparation of a decision.

Question 42b. What is the projected impact on BVA output?

Answer. It is unclear what the extent of this new workload will be. The Board's best estimates indicate that initially about 25 percent of the appeals caseload will require development, thus reducing the decision output by that amount.

Question 43a. In the past year, since the passage of the "Veterans Claims Assistance Act," VBA has slowed the volume of cases it sends to the BVA as it reworked affected claims. Please provide the monthly input and output of cases for the last 12 months.

Answer.

Month	Receipts *	Decisions
February 2001	1,396	3,023
March 2001	1,155	3,503
April 2001	1,315	2,720
May 2001	1,827	2,798
June 2001	971	2,396
July 2001	1,737	2,233
August 2001	1,669	2,215
September 2001	1,096	1,780
October 2001	1,392	1,878
November 2001	688	1,228
December 2001	1,620	881
January 2002	1,620	1,077
Total	16,486	25,732

*Consists of all cases physically received at the Board, including original appeals and cases returned to the Board's docket (i.e., cases returned following remand development, cases remanded by the Court, and cases received for reconsideration or vacate actions).

Question 43b. Describe the number of travel board and satellite hearings conducted, and requests still outstanding.

Answer. Shown below is the number of travel board and video hearings conducted over the last several years:

Fiscal Year	Travel Board	Video
1997	4,564	233
1998	2,469	1,151
1999	3,512	1,282
2000	2,505	1,385
2001	3,336	1,308
2002 [Four Months]	600	479

At the end of January 2002, there were 6,975 pending requests for travel board hearings. Of those, 1,558 were certified by VBA as ready. There were 1,523 pending requests for video hearings. Of those, 310 were certified as ready.

NATIONAL CEMETERY ADMINISTRATION

Question 44. What is the status of each of the six new cemeteries authorized in 1999? Is the funding requested for FTE sufficient to staff the new facilities that will be open and is the construction funding sufficient to complete the last two projects?

Answer. The status of the efforts to establish six new national cemeteries is described below. The 2003 budget request for the National Cemetery Administration (NCA) includes sufficient funding ($4.8 million and 30 FTE) for four facilities which will require operational funding in 2003. These resources will support interment operations on fast-track parcels completed as a part of Phase I construction of new cemeteries at Ft. Sill, Oklahoma, and Atlanta, Georgia, and to prepare for the activation of interment operations in 2004 on fast-track parcels to be completed for new cemeteries in Southern Florida, and in the vicinity of Pittsburgh, Pennsylvania. There are no 2003 operational funding requirements for the two remaining sites at Detroit and Sacramento.

The 2003 Major Construction budget for NCA includes sufficient funding to continue progress in developing new national cemeteries. Resources are requested for Phase I construction of the new cemeteries in Southern Florida and near Pittsburgh, Pennsylvania. The 2003 budget also includes additional funding for design of the new cemeteries planned in the areas of Detroit, Michigan, and Sacramento, California. Full construction funding for the new cemeteries at Ft. Sill, Oklahoma and Atlanta, Georgia was provided in the 2001 and 2002 budgets respectively.

The status of development of the six new national cemeteries follows:

FT. SILL, OKLAHOMA: A fast-track burial section was dedicated in November 2001, which will allow interments to begin prior to full completion of all construction activities at the new cemetery. The Phase I construction contract is planned to be awarded in March 2002. Funding for all Phase I design and construction costs was provided in prior year appropriations.

ATLANTA, GEORGIA: An Architectural/Engineering (A/E) firm has been selected to develop the master plan for the new cemetery. The contract should be awarded in March 2002. Funding for all Phase I design and construction costs was provided in prior year appropriations.

PITTSBURGH, PENNSYLVANIA: The environmental assessment process on the preferred site was completed. The land acquisition process is currently underway. When this process is complete, master planning will begin. Resources for master planning and land acquisition were included in the 2001 and 2002 appropriations respectively. The 2003 President's construction budget requests $16.4 million for Phase I construction.

SOUTH FLORIDA AREA: The environmental assessment public comment period for the evaluated sites ended in January 2002. A boundary survey and title search is currently being conducted. When land acquisition is complete, master planning will begin. Resources for master planning and land acquisition were included in the 2001 appropriation. Funding for design was included in the 2002 appropriation. The 2003 President's budget includes $23.3 million for Phase I construction.

DETROIT, MICHIGAN: The environmental assessment public comment period for the evaluated sites ended in January 2002. A boundary survey and title search is currently being conducted. When land acquisition is complete, master planning will begin. Resources for master planning and land acquisition were included in the 2001 and 2002 appropriations respectively. The 2003 President's construction budget requests $1.7 million for the design of this new national cemetery.

SACRAMENTO, CALIFORNIA: The environmental assessment of potential sites is in process. This process should be completed in March 2002. Resources for master planning and land acquisition were included in the 2001 and 2002 appropriations respectively. The 2003 President's construction budget requests $1.7 million for the design of this new national cemetery.

Question 45. Please provide a breakdown of the minor construction NCA projects. How does this compare to the findings in the study that is to be submitted pursuant to Public Law 106–117?

Answer. The 2003 President's budget requests $21 million of Minor Construction funding for the National Cemetery Administration. Of the requested amount, $18.9 million is for projects to continue service delivery by providing additional gravesites or columbaria niches at existing national cemeteries that are nearing depletion of their inventory of burial space; $1.6 million is for irrigation projects which will improve national cemetery appearance; and the remaining $500,000 is for building construction and other site improvement projects.

Data from the facility condition assessment study required by Public Law 106–117 is not yet available. A draft report submitted by the contractor conducting the study is currently under review. We anticipate that the study findings will be transmitted to Congress in May 2002. When the study is completed, a comparison with the minor construction request will be performed. The study will identify repairs needed to ensure that national cemeteries are maintained as national shrines. The study will not address gravesite expansion projects necessary to provide burial space for veterans and their eligible family members.

Question 46. The State Cemetery Grants Program has proven to be a popular alternative for states with diffused or small veteran populations as a way to honor and commemorate their veterans. I'm pleased to see that the budget request provides a $7 million increase in the funding for the program.

Have any requests been denied in the last two years due to lack of funds?

How many projects is this increased appropriation expected to finance?

Do you anticipate an increased demand for the program since the increase in the plot allowance provided in Public Law 107–103 that will go to offset the states' operational costs?

Answer. The State Cemetery Grant Program appropriations provided in 2000 and 2001 have met program needs. There were no grant requests denied due to lack of funds. The $32 million requested in the 2003 budget is expected to fund nine projects.

The change in the plot allowance resulting from enactment of Public Law 107–103 increases the amount paid for an eligible veteran not buried in a national cemetery from $150 to $300. This increase should encourage states to participate in the State Cemetery Grants Program, but it is too soon to determine the extent of the impact this increase will have on demand for State Cemetery Grant Program fund-

ing. Texas, Washington, Michigan, Mississippi and New York, among others, have expressed interest in requesting funding for state veterans cemeteries.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JAMES M. JEFFORDS TO ANTHONY J. PRINCIPI

Question 1. I appreciate that you have had to press hard for the funding increases for veterans programs, but I am concerned that the budget before us is not adequate to meet our needs. While it contains an increase of $1.4 billion over last year's levels, the Independent Budget estimates that an additional $1.7 billion is needed to adequate funds current services. Your budget also contains some pretty rosy assumptions, such as an additional $500 million in third-party collections above this year's projected level.

I am also concerned about the decision to request a new annual $1,500 deductible from all Priority 7 veterans. Many VISNs, and New England is one of them, have worked hard to enroll new veterans and to reach the large population of veterans who have never stepped foot in a VA facility. It would seem that this initiative could seriously undercut that effort.

I would appreciate you commenting on both of these matters.

Answer. An additional $1.4 billion in appropriation (excluding the retirement accrual transfer and including management savings, $1,500 cost share deductible and increases in revenue, reimbursement, and unobligated balances availability) provides funding for:

- Current service requirements
- Our enrolled population, which is requiring more health services as that population ages
- Pharmaceutical increases as a result of new patients accessing the system for their pharmaceuticals coupled with the increased treatment of enrolled patients in the ambulatory care environment
- Prosthetics and sensory aids due to the continuing impact of mandated eligibility reform
- CHAMPVA for Life,
- Continuing open enrollment
- Faith-based and other Community-based programs
- Outpatient dental care for former Prisoners of War
- Newborn care as a part of basic benefits

The Independent Budget recommends a $3.1 billion increase over the FY 2002 appropriation. The Independent Budget does not take into consideration the effects of management efficiencies, the $1,500 annual deductible for Priority 7 veterans, or improved collections on the appropriation level.

The FY 2003 budget projects a $418 million increase for the Health Services Improvement (HSIF) and Medical Care Collections Funds (MCCF) over the FY 2002 current estimate. The primary reasons for the increase are the medication copayment (increase from $2 to $7), proposed legislative initiative for the $1,500 deductible, anticipated revenue from the long term care copayment, and improvements derived from the Revenue Improvement Plan, Electronic Data Interchange (EDI), Centralization & Consolidation, and Outsourcing & Contracting. All of these will all have a profound impact upon the HSIF and MCCF programs to help increase the level of collections.

Recent collections have increased significantly from earlier estimates. For example, actual collections in FY 2001 exceeded the original budget estimate by over 26 percent.

The following addresses the policy considerations made in regards to the $1,500 deductible proposal. Continued growth in the demand for VA health care services will require significant increases in budget resources. Without significant increases in resources or the implementation of an alternative policy/policies (e.g., limit enrollment, change uniform benefits package, cost share proposal), VA would face critical issues impacting quality, such as, increasing waiting times, increasing system congestion impacting all patients, inability to meet demand. VA considered these policies and determined that the deductible (cost sharing) proposal seemed to be the preferable option that addresses the following most overarching concerns:

- Maintain quality of care for all those that VA serves.
- Continue VA open enrollment for all veterans.
- Maintain, not reduce, the basic benefit package of medical services for core veterans.
- Provide veterans appropriate access to outpatient, inpatient, and non-institutional long-term care services.

• Require veterans that have higher incomes to contribute more to their cost of care than other veterans.
• Assess a charge for use of healthcare services as opposed to assessing an up-front charge or enrollment fee.
• Allow veterans to benefit from private insurance coverage and would encourage veterans to identify their insurance coverage.
• Continue VA long-term services, especially non-institutional care.
• Provide catastrophic coverage for those with high annual medical costs.

Question 2. Your budget proposes to move employment and training services for veterans out of the Department of Labor and into the VA. While I appreciate the effort to avoid duplication of services, I do not believe a strong case has been made by the VA to explain how they could run this program better. In fact, having worked for many years on job training issues, I would prefer to see the focus on improving the program at DOL. That is where the expertise on job training lies and I believe we would be wise to first try a through reform effort before uprooting the program entirely. I would appreciate your views on this.

Answer. It is clear that the DVOP and LVER programs have not served veterans' job search assistance needs well for a long time.

The Commission on Servicemembers and Veterans Transition Assistance (Commission) report and at least six GAO reports issued in the past five years extensively document long-standing shortfalls with the DVOP and LVER programs. In spite of the public awareness that these two programs, as currently administered, are failing far short of the excellence we should demand of programs so important to many veterans' ability to enjoy the secure and productive life that their service defended for all Americans, change to the programs has not occurred.

While the challenges to VA are real we are confident that the mission of this Department to serve veterans is clear and focused. That is an important distinction since the programs involved are limited to and focused specifically on veterans. Unencumbered by a long history and long-standing relationships, VA can much more easily evaluate veterans' employment assistance needs and develop a program that better meets the needs of today's veterans and ensures adequate flexibility in design to allow for adapting to the needs of tomorrow's veterans.

Question 3. As you know, many VA hospitals are having a very hard time recruiting procedural specialists. The VA has always had a lower pay scale than the private sector. But because a VA job brings other advantages, the VA has usually had good success in recruiting top specialists. But as the gap widens between VA salaries and the private sector, many medical centers are finding it increasingly difficult to hire procedural specialists. This could have a very significant effect on the level of care the institution is able to provide.

Have you examined this issue of the competitive pay scale? How big a problem do you see it to be? How can this issue be addressed before it has a significant effect on health care quality?

Answer. The amounts of special pay authorized for physicians have not been adjusted since 1991 and are less competitive for many specialties and categories of physicians. After 1991, physician staffing stabilized or improved in most medical categories. However, VA's current competitive situation is eroding in many areas of the country and will continue to erode due to the 11-year old limits on special pay amounts. The Administration is about ready to propose legislation (for the short term) to address physician's special pay. We are also exploring long-term solutions.

VA salaries for some scarce subspecialties, such as anesthesiology, radiology, cardiology, and surgical subspecialties, are far behind the salaries offered by non-Federal institutional employers. VA is able to assure quality care to veterans through the use of contracts. When VA cannot offer a competitive salary to a highly paid specialist, then VA must obtain the service on scarce specialty contracts, often at significantly higher cost.

VA is in the process of developing its findings for the Quadrennial Report to the President on the Adequacy of Physician and Dentist Special Pay. Those findings will form the basis for recommendations for comprehensive compensation reform to ensure that VA is able to capitalize on its advantages in attracting and employing specialists and other direct care providers.

Chairman ROCKEFELLER. Thank you, thank you very much, Mr. Secretary, and that was candid. When you were up for confirmation, I asked if you would be candid? And today you were candid. You were doing two things. You were saying I am a member of the administration, but I want to take care of the veterans. I do not think that we can ask for more candor than that.

I want to bring up something which is sort of out of order, and that is long-term care. Here we are, talking about the year 2002, when Congress passed long-term care changes in 1999. It took 2 years to get interim guidance, and that guidance is weak. The question I am going to ask you is when are we going to get a final directive? I am speaking about noninstitutional long-term care—the first long-term care benefit involving the Federal Government that has been passed since Medicare.

Along with the lack of mental health parity—long-term care is 1 of the 2 great health care needs that we consistently ignore in this country. But in the law, we said under section 101, VA is required to provide noninstitutional extended care services. In the interim guidance which came out after 2 years, you have very different language—and that is all VHA facilities are either to have these services available to their veterans or to incorporate into their strategic plan a process for establishing the access of these services.

I am really concerned and upset about the inaction, because long-term care was a very serious matter that Senator Specter and I negotiated in conference. We thought we were going to meet resistance on the other side of the Capitol, we did not. And it is something that is tremendously important for the veterans. I want to know when are we going to get a final directive? And is it going to follow the law?

Secretary PRINCIPI. Yes, Senator, I will try to be brief.

We are not in compliance with the law. I apologize for that. I have asked the Acting Under Secretary for Health to give me a plan by March 15 on how we will be in compliance with the law. I want to know where the additional nursing home beds will be; a timeline for activating those nursing home beds; the cost of activating those nursing home beds, both recurrent and nonrecurring costs; and what will we use to pay for them? In other words, there will have to be an offsetting program savings somewhere within our budget.

It will cost us approximately $150 million to be in compliance with the law. We will have to take that money from other programs. At the same time, I will request that the committee seriously consider changing the law so that it does not put just a floor on VA nursing home beds but looks at our state nursing home program, our community nursing home program and the advances we are making in noninstitutional care. We have expanded our state nursing home beds census rather significantly over the past several years, but that does not count. We have to have a floor on VA nursing home beds.

Chairman ROCKEFELLER. Are those equal beds on par, as you describe it?

Secretary PRINCIPI. Are they equal? Let me ask Dr. Murphy to answer whether the services are actually equal. I do not think that is true in community nursing home beds. I think VA is the best, but I think the State——

Chairman ROCKEFELLER. But I want to make sure that when you are talking about beds, you are talking about services.

Dr. MURPHY. As long as the beds are staffed, they would be equivalent. To be absolutely clear, we are looking for a level of the average daily census to be the same as 1998. That way, we know

that veterans are actually getting the long-term care that you have determined they are entitled to.

Secretary PRINCIPI. Does that answer the question?

Chairman ROCKEFELLER. Yes, and I will just need to wait. You say it is going to be March?

Secretary PRINCIPI. Yes. I have asked this morning—earlier this morning, I asked for a plan by March 15. I think the time——

Chairman ROCKEFELLER. You need to. You need to.

Secretary PRINCIPI. If we cannot reach an agreement that we need to change the law to reflect noninstitutional and non-VA provided care, then we need to be in compliance. But there will be costs. We know that.

Chairman ROCKEFELLER. And you do agree that that is the direction of veterans' health care?

Secretary PRINCIPI. Noninstitutional?

Chairman ROCKEFELLER. Yes.

Secretary PRINCIPI. Absolutely.

Chairman ROCKEFELLER. Yes.

Secretary PRINCIPI. I think we do need institutional nursing home beds. Veterans with Alzheimer's and dementia cannot be easily kept in the home. So I think we do need to fulfill a certain commitment, in VA, the State, and in the community. But at the same time, veterans and their families benefit the longer we can keep them in their own homes with the noninstitutional programs: the hospital-based home care; the respite care, where the veteran goes into an institutional setting for a couple of weeks so the caregiver can get some rest; the adult day programs where veterans go into the hospital for 8 hours so that they can exercise and be involved therapeutically and then return home in the afternoon. Those are wonderful programs.

Dr. MURPHY. Senator, if I could add, I think you would be pleased to know, that VA has projected that in 2002, the number of veterans receiving home-based care, noninstitutional care, will increase by 54 percent. Also the current budget requests additional resources for the 2003 allocation, and we project a 91 percent increase or over 26,000 ADC for noninstitutional programs. So we are very aggressively building our home-based extended care programs, and we know that that was the mandate in the Mill bill. In addition to addressing the institutional VA nursing home beds, we will be aggressively addressing the noninstitutional care.

Chairman ROCKEFELLER. My time is up. I want to get behind this. It is the law. I recognize the costs involved, but together, we have an obligation to work that out.

Senator Specter?

Senator SPECTER. Thank you very much, Mr. Chairman.

Secretary Principi, I start with the business about the $1,500 deductible, starting at $28,000 a year annual income. On its face, that is simply not acceptable. Somebody who earns $28,000 a year is not in the position to undertake a $1,500 deductible. Means testing is something which is generally rejected as a matter of Federal policy, and to impose a deductible on veterans seems to me to be unduly harsh because veterans are not getting gifts or gratuities. They are being given medical services as a contractual matter for the service which they performed for their country.

When you say that no veteran will go without benefits and medical services, and if they can only pay $10 a month, so be it, that kind of approach is not realistic or doable under the proposal which has been made. If you call for a $1,500 deductible, that is that. And the veteran is going to have to pay that amount of money in order to receive any benefits. So what I would like to see you do is go back to the drawing board. Figure out what this deductible would produce by way of revenues, and figure out what you can produce from other sources, and then determine whether it really is necessary, or indispensable, to impose a deductible. When other alternatives have been exhausted, then determine what is the income line where VA ought to impose a deductible. I know it is not $28,000. It may be your salary. What did you say your salary was? [Laughter.]

Secretary PRINCIPI. Same as yours, Senator.

Senator SPECTER. Next time you appear, I want you better prepared. I want you to know your salary, Mr. Secretary. [Laughter.]

And on the issue of insurance collections, you stated that not all veterans have insurance coverage. And you stated that the amount of money collected from the insurance company might be offset against the proposed annual deductible. Well, that really is not a practical way of dealing with the issue to try to deal with veterans that have insurance. But to return to the issue of doctors not filling out forms to submit to the insurance companies: that situation is intolerable. They do not miss a beat on filling out forms when their compensation is at stake and I understand their motivation for doing that. But they are part of the system, and I would like to know what your thoughts are about imposing a little discipline to require the doctors to fill out those forms, and if not, then what? How about a little threat here? How about a little discipline here?

Secretary PRINCIPI. Certainly, it is very important that the documentation take place. If we do not code, then without the proper documentation, we cannot bill. And the physicians are the only ones who can ensure proper documentation. If they are not doing that, then, I do think we have to take some action, because the veterans are being penalized because we are not able to collect from insurance companies.

Senator SPECTER. Would you give some thought to that?

Secretary PRINCIPI. I will.

Senator SPECTER. And give us a written response within 2 weeks as to what you propose to do to get VA doctors to do their duty and fill out these forms?

Secretary PRINCIPI. Yes, sir.

[The information referred to follows:]

I am considering a variety of alternatives that will lead to significant improvements in VA's third party billing operations.

The tool that I believe will be most effective is to identify specific performance goals related to the timeliness and accuracy of each component of our billing process, and to establish performance standards pertaining to documentation for medical center directors, chiefs of staff, and attending physicians. We are currently exploring options to link physician pay to performance. If needed, we will seek legislation to provide us the authority to implement this, possibly as part of a broader legislative package we will submit later this year on a variety of special pay provisions for VA physicians.

I fully expect that incorporating billing documentation requirements into physician performance standards and linking these to pay will improve compliance. How-

ever, I expect the Under Secretary for Health to turn to traditional disciplinary measures in instances where any physician repeatedly fails to meet documentation standards. If a specific provider does not comply with requirements following education/training and feedback from monitoring efforts, specific management actions would include validating the understanding of requirements and determining willfulness of noncompliance. Disciplinary steps for a full-time permanent physician could then include formal counseling, admonishment, reprimand, 15-day suspension and, finally, removal depending upon the seriousness and nature of the non-compliance. For part-time, temporary or physicians in a probationary period, only one or two warnings are required before moving for termination.

As noted, the most significant requirement for physicians is to provide thorough and timely documentation in the process of cost recovery. For outpatient care, this includes notes describing the treatment provided during the visit in order to allow billing for an office visit or consultation. With regard to inpatient care, documentation requirements apply to notes regarding the reason for the admission so as to allow professional billing for the first day of the stay; notes during an inpatient stay as the patient's condition changes; operating reports completed immediately after surgery; and notes at the time of patient discharge. To assist physicians, we have developed and implemented software allowing the electronic entry of practitioner identification, lists of patient problems, diagnosis, and treatment provided.

While setting clear performance requirements and holding physicians accountable for their performance will be the most effective strategy to use in improving our billing process, there are other important steps we are taking that will lead to better outcomes. For example, we have already established compliance policies and guidelines through official directives issued to all Veterans Integrated Service Networks (VISN) and medical centers. We are supplementing this with ongoing staff education and training to reinforce the requirements outlined in the directives. In addition, we established a physician education task force charged with developing a toolkit that will provide physicians with easy-to-use references and reminder materials. Recognizing the importance of monitoring compliance with key policies and procedures, we are implementing a national monitoring program that will be instituted in all VISNs and medical centers. The results of this monthly monitoring program will be reported to VA Central Office for review and follow-up action.

I am firmly committed to improving all facets of the Department's billing and collections operations. As a result of new steps to enhance physician accountability for performance as well as the other improvement strategies I have outlined above, I am confident that our performance will be markedly better in the future.

Senator SPECTER. Let me pick up on the issue of homeland security for the very brief time that I have left. Congress last year appropriated more than $3 billion for homeland security. We did not want to wait for this year's budget to fund homeland security. We put up $1.050 billion for public health services and then very substantial additional money for smallpox vaccinations and for purchases of Cipro to guard against anthrax, and for other items.

You have, as you describe it—how do you describe it—the largest public health system in the world?

Secretary PRINCIPI. Certainly the largest integrated health care system in the world and a system completely under Federal control in every community in America. So all of our employees are Federal employees, and I think are a wonderful resource in the event of a man-made or a natural disaster.

Senator SPECTER. Senator Harkin and I are going to be meeting this afternoon with Health and Human Services Secretary Thompson about preliminaries for his budget, and I am going to ask him to call you, and I am going to ask you to call him—your calls may intercept one another—to get your department involved. You have a great public health system all set up, and $1 billion is a good start on public health in America, but it is not going to do the whole job. When you get wholesale minus 24 percent—that is what you get on pharmaceuticals?

Secretary PRINCIPI. That is a starting point because we can negotiate below that price.

Senator SPECTER. Well, that is a starting point. You ought to be involved in expending the large sums of money which are going to be spent on pharmaceuticals for homeland defense.

Secretary PRINCIPI. Absolutely.

Senator SPECTER. My staff will be here to hear the balance of the testimony. We will follow very carefully what the service organizations have to say. Bill Tuerk, who is a veteran of these committee hearings, has already talked to the service organizations, and we will give very heavy weight to what the service organizations have to say. I regret that I have got to go to a budget hearing on Coast Guard, again, on homeland defense, and I thank you, Mr. Chairman.

Chairman ROCKEFELLER. Thank you, Senator Specter, and thank you for coming. And we were talking earlier about how busy it is around here, when many of us serve on five committees and everything takes place at the same time. So we appear rude, and perhaps sometimes, we are, but we do not intend to be.

Senator JEFFORDS. Mr. Secretary, I am very concerned about the funding situation in the current year. Overall, the VA health care system may be as much as $400 million short. We are expecting a deficit of over $40 million. Even assuming we meet the optimistic third-party collection targets, coming on the heels of several years of inadequate funding, most medical centers have already squeezed as much as they can out of their programs and put off needed maintenance and repairs.

We in VISN 1 are committed to serving the Priority 7 veteran population, it should not have to come out of the expense of other programs. I understand that the administration plans to request additional funding for VA care somewhere in the neighborhood of $140 million. Do you believe this amount will cover the actual cost of Priority 7 veterans' care?

Secretary PRINCIPI. The $142 million will not entirely cover those costs. I think the $142 million will certainly go a long way to meeting the workload growth of Priority 7's in 2002. We are taking other steps to be more efficient, both medical care cost recovery—I will let Dr. Murphy talk in a moment about the additional money that will be going up to the Vermont VISN this year.

Senator JEFFORDS. My back of the envelope calculations—it looks like it would be about $40 million short up there. I just want to leave that——

Dr. MURPHY. Senator Jeffords, we know that VISN 1 is making the best use of their resources, and they are challenged this year. We have sent them an adjustment to their VERA budget allocation already, as you know. And in looking at how we can deal with the shortfall in the 2002 budget, we made some efficiencies in our centralized funds, and we will be reallocating over $160 million out to the field through VERA.

In addition, we expect to be getting a supplement of at least $142 million. With the combination of those two additional funding sources, VISN 1 will be getting at least $14 million in addition to the adjustment that has already been made. We know that if they could complete the Boston integration between the West Roxbury

Medical Center and Jamaica Plains that they would save a substantial amount of money. And we will be sending some additional minor construction dollars to speed that integration along and to allow them to become more efficient and hopefully to live within their VERA allocation in future years.

Senator JEFFORDS. I appreciate that information.

Thank you, Mr. Chairman.

Chairman ROCKEFELLER. Thank you, Senator Jeffords.

Senator Nelson?

Senator NELSON. Thank you, Mr. Chairman.

Mr. Secretary, as I indicated earlier, I am concerned about VISN's 13 and 14 being merged together and having it presented as a done deal as opposed to a proposal that might come before this committee as part of the budget. And as I look at what is being proposed, I question whether or not merging two VISN's together that neither is doing well will somehow make a healthy VISN to begin with.

And I think part of the shortfall that is projected is on the basis of determining what the needs for that VISN are to begin with. If you look at the $1,500 deductibility in the Priority 7 veteran category, we may have a false assumption at the very beginning as to what the needs truly are, whether or not people in the farm states truly should be in Category 7 based on assets. Do they have to sell the farm to get care?

And I think that is, in fact, a part of the difficulty in determining what resources should have been put into the VISN in the first place which I think were underfunded because of a basic false assumption as to the ability of some of the veterans in the area to pay. I would like to have us go back and address that. I would like to invite you to Nebraska to talk to people on the ground, either informally or through a field hearing or in some capacity to truly find what the challenges are, because there are three As about it. Affordability is obviously one of them; availability and accessibility, and if it is not accessible, I can assure you it is not available. And if it is not affordable, then the other As are in doubt as well.

So I am hopeful that we can work through this. I am concerned about the ability of people to pay, and certainly, Category 7 or Priority 7 veterans need to be addressed. I am also mindful of finding a way to stretch dollars to meet the needs. I am not callous toward that, nor am I particularly parochial about Nebraska or our surrounding area. This problem exists in other states as well, and so, we are committed to work with you in every way that we can, but the bottom line is we have to find a solution. And if we can do it together, I think it is better than if we are trying to find it separately and work it at counterpurposes with one another.

And so, I appreciate this opportunity; thank you, Mr. Chairman, and we will be getting back in touch with your office about the possibility of a field hearing on this merger.

Secretary PRINCIPI. I would be happy, Senator Nelson, to visit Nebraska with you and to do a town hall meeting together or to do a field hearing. Call the chairman, and we can work out a mutually convenient date, I am sure, in the very near future.

Perhaps Dr. Murphy can add, but I would just like to say at the outset in case there is a misunderstanding: at one time, we had

seven what you might call VISN's. We then went down to four regional headquarters. Then, a change was made in the mid-1990's to go to—we called them regions back then—to go to 22 VISN's or networks. So there is really no magic number, sir. I tend to think that we have too many, but the cost and the instability of consolidating more are important factors. We had an opportunity to take two very small networks, Networks 13 and 14, and bring them together. But, sir, all we did was combine the administrative overhead, about 15 or 20 people in each office. None of the hospitals or the clinics were, so to speak, merged. None were closed.

The only thing we did was to take a look at the admin offices that oversaw the respective VISN's and put them together. Even with the combined admin office, 13 and 14 combined is one of the smallest networks. I thought a compelling business case was made to put that overhead together and I certainly made that decision. But I would be more than happy to come out to Nebraska and talk about the decision and the rationale and what we need.

I visited Omaha not too long ago. We have a wonderful hospital in Omaha, and it will stay as a vibrant hospital.

Senator NELSON. Thank you, Mr. Chairman.

Thank you, Mr. Secretary.

Dr. MURPHY. I think the Secretary has made a very important point. The merger of Networks 13 and 14 into a single network hopefully should be completely transparent to the veteran, because they will be seeing their same doctor at the same clinic or medical center that they did prior to the merger. This is really an administrative efficiency and hopefully will allow us to recruit an energetic leader who will help solve some of the financial problems.

The other thing that you mentioned was the Priority 7 funding issue. We will be looking at some adjustments to the VERA allocation model this year with the help of the RAND Corporation Study. And we may be looking at a mechanism to fund Priority 7 veterans and a way to risk-adjust for the most complex patients and to appropriately fund networks who have both more Priority 7's and more seriously ill patients. I think both of those will help the funding levels in the new Network 23.

Senator NELSON. Mr. Chairman, if I might, just 1 second. I heard you say and I have heard it as well that one of the reasons for merging the VISN's is that it might be easier to find a more energetic person. I think there are energetic people in Nebraska. I know that is not what you are suggesting, but I heard that as part of the explanation, that we could not find somebody where the VISN's were currently located to do it, but we might be able to find somebody by merging them.

And I do not understand that logic. I really do not. I will help you find somebody if——

[Laughter.]

Senator NELSON. I am not in that business, but I can sure get into that business real quickly if that seems to be the challenge. But I know that it is more than that, but I did not understand that at the beginning. You do not need to respond to it. It is just something—I just want the record to reflect that there are energetic, well-educated and talented people in our area as well. [Laughter.]

Thank you.

Dr. MURPHY. And I did not mean to suggest otherwise.

Senator NELSON. I know you did not. I know you did not.

Chairman ROCKEFELLER. Nobody will dispute that.

Senator NELSON. OK; thank you.

Chairman ROCKEFELLER. Is that all, Senator Nelson?

Senator NELSON. That will do it. Thank you.

Chairman ROCKEFELLER. OK.

Senator NELSON. And I have to get back to the Armed Services, too, so thank you.

Chairman ROCKEFELLER. I am very interested when you talk about Nebraska as being geographically challenged, because I think of all of the flat land in Nebraska, and I think of West Virginia as having only 4 percent flat land and 96 percent mountains. I am trying to figure out how you are challenged. [Laughter.]

Senator NELSON. Well, the difference, Senator, may be that your population lives on that 4 percent of your land that is not mountainous. Ours is flat, and people live everywhere. It is just that there are not very many of them. [Laughter.]

And it is as far from the western part of the State to the eastern part of the State, from the Wyoming border to the Missouri River as it is from the Missouri River in Nebraska to Chicago. So it is a challenge. Thank you. I invite you to come out.

Chairman ROCKEFELLER. Thank you, Senator.

Mr. Secretary, there are four more questions now that I have the place to myself—that I wanted to ask. And one is to followup on something that Senator Specter was talking about, and that is the homeland security aspect. I mean, let us face it: philosophically, what makes this year so hard—and probably the next 25 years so hard—is that we are fighting a war on terrorism. This takes an enormous amount of resources, and nobody questions, in general terms, those resources. And yet, you do not stop the work of being a country, and people do not stop having needs.

So we go into budget deficits. I cannot object to that, because we have to get things done, and veterans really need to be at the head of that list. So, I mean, things become harder, but it cannot ultimately be an excuse for us not doing what needs to be done. So with that as a preface: let's talk about your internal committee recommended for preparedness. Emergency preparedness is huge in the present-day context. I mean, you know, that we have got an alert out now, and will for many years to come.

You recommend a minimum budget of $118 million to equip hospitals with necessary staff, training and materials for disasters, particularly for bioterrorism. And there is just a lot of talk about that happening. VA's 2003 budget includes only $55 million for all emergency preparedness, and VA got $2 million, barely enough for its existing HHS obligations, from the Defense supplemental. How do you work that? I mean, everybody has got to get to the table on this subject of preparedness. Everybody agrees that the VA hospitals are an absolute national resource, which a lot of even my colleagues do not recognize, because they are thinking in sort of more conventional terms. But this is an enormous resource, and we have been talking about it for awhile.

How do you justify this?

Secretary PRINCIPI. Unfortunately, the VA is not thought of when some of the decisions are being made, if you will, on homeland security. You think of addressing the health care needs, and rightfully so, the funding goes to HHS and other security needs, homeland security. It is not that we are not at the table discussing these issues. We are fighting; we are working with HHS and Homeland Security for part of the resources that are being made available to those agencies to address the bioterrorism threat.

I just believe that the VA has such enormous capability and size that we can bring great value and preparedness to this area. But like everything else, to build toxicologic capacity, burn capacity, decontamination and the other capacities, you have to invest resources. And I am very reluctant to take scarce resources, obviously, from treatment of veterans to devote to this area without the additional resources necessary to do so.

Chairman ROCKEFELLER. So, then, should you not go scare the dickens out of the appropriators? VA is a national resource, and therefore we need to take them through what the other alternatives are. Private hospitals cannot do it alone. A couple of them are preparing in my state of West Virginia, but they cannot afford to do everything—80 percent of our hospitals are losing money.

You are on a budget. It is strictly up to the Appropriations Committee. They purport to be highly interested in national security and homeland security, and VA is central to that. I mean it is sort of a question of being sort of brutal with them, is it not?

Secretary PRINCIPI. Absolutely; I agree, and we will. Perhaps we need to articulate our case better. That is not to say we are not working with them. I do not want to misrepresent the situation—we are working very, very closely with HHS and Homeland Security. Dr. Murphy can talk more about the specifics. But clearly, the funding has not been what we believe is necessary to have that level of readiness, if you will. And again, I think the beauty of the VA is the fact that—not only that we are dispersed throughout America but that we are under complete Federal control, and Dr. Murphy, or whomever, can direct people to do things if it is necessary.

That is a little different than in the private sector. The private sector does not have that level of control and direction. We do. I believe we procure the pharmaceuticals for the caches that are prepositioned around the country in the event of a national emergency. I also believe we have purchased—you can go into more of the detail, Dr. Murphy—other drugs that are needed by HHS. Clearly, more needs to be done, and it requires funding.

Dr. MURPHY. If I could add to what the Secretary said, I think there is a basic lack of understanding of the VA health care system. We are part of the Federal public health infrastructure. And when you talk about planning for improving the public health infrastructure of this country, VA needs to be seen as a core part of that. The public health resources are now going out to the States and the communities. Well, VA is part of those communities, and we need to be an active player. If we are going to provide the kind of matrix needed for a Federal cadre of health care providers in this country, the one organization that can do that—that is on the ground, taking care of patients and can help lead in a time of na-

tional emergency—it is the VA. It is the VA health care providers and their expertise.

We have begun a national training program for all of our health care providers in emergency preparedness. Each of our medical centers has been given a guidebook on how to develop an all-hazards plan. We have made a proposal and begun putting together pharmaceutical caches that will be located at each of our medical centers, and depending on the size of the community or the size of the veteran population, they will be prepared to take care of either 2,000 or 1,000 individuals who might have been exposed to a chemical or a biological attack.

So far, we have purchased enough for 22 sites, and over time, we will be, you know, as quickly as possible, putting them together and locating them at each of our medical centers.

Why do that if we have national caches? Well, because if there is an emergency, we want to be able to take care of veterans who are hospitalized and our staff, so that they can continue providing care. It is a necessary part of being a health care provider. We need to do that. We also need to have decontamination equipment, and we need to have personal protective equipment so that our staff can be protected and continue to provide the care that is so important not only for the veterans but for the communities that we work in.

And I think that it is a deficiency of the current plan that VA has not been given a more active role. It is part of our primary mission, and it is part of our fourth mission.

Chairman ROCKEFELLER. So make your case.

Secretary PRINCIPI. Will do.

Chairman ROCKEFELLER. And I know you will. I know you will.

One thing on copayments—I have already made a point, as has Senator Specter, but this is interesting to me. I think this is the first budget where you anticipate collecting more revenue from veterans than you do from insurance companies.

Secretary PRINCIPI. That is correct.

Chairman ROCKEFELLER. And it is a little bit odd, because, on the one hand, we can say we are providing more money to VA, but then, VA turns around and collects huge amounts from veterans, rather than insurance companies.

Secretary PRINCIPI. Yes, of course, and that increase includes the deductible; you are right.

Chairman ROCKEFELLER. I know that, and you were very candid about that in your opening statement. You were very candid about all of that.

On claims processing, your goal for the coming fiscal year is to go to 100 days, down from 208 days, while still increasing the accuracy of the decisionmaking, and perhaps this is you, Mr. McMichael. What specific measures do you expect will shave that kind of time off? Whenever I hear something that is that good, I want to hear how it happens without sacrificing the accuracy factor.

Secretary PRINCIPI. Important point, Senator, and that is by the end of the third quarter of 2003, we hope to have achieved that goal. I will let Guy McMichael talk about the particulars. I think that there are a couple of factors that Guy can build on. First, Con-

gress and the administration gave us over 1,000 people last year: 1,100 or 1,200 people, the vast majority in our disability compensation arena. Those folks have been trained. That will make a big difference.

Chairman ROCKEFELLER. And I have seen some of the technology. You have unique technology.

Secretary PRINCIPI. They are good, young, talented people that I see around the country. We will hire another 100 to 125 people in 2003. If I need more, I will come to you and ask for more. We have those people now on board, getting them trained. And I believe that Admiral Cooper's task force has come up with some excellent recommendations that, by triaging, specialization, the tiger team to address the claims of the oldest veterans, I believe will help us get there.

Am I convinced that we are going to achieve it? I am optimistic, but are watching it very carefully. Every month, Guy briefs me on where we are, what our performance has been for the previous month, and our production goals. We are looking at measuring quality. We are adding people to our review teams. Our quality has never been higher—at least I should say our accuracy, because our quality is timeliness, too, but our accuracy is at 88 percent. You know, it was 59 percent in the year 2000, so our accuracy is very, very good.

It is going to take a lot of disciplined, focused leadership, and people are going to be held to high performance levels. There have not been performance standards in the past, and we have those now. People are responding. I am very, very gratified by what have I seen. Guy, could you add to that, please?

Mr. MCMICHAEL. Well, the Claims Task Force had 34 principal recommendations which we have translated into 66 action items. I have had the opportunity to brief your staff on these matters, Mr. Chairman. I think the important thing is there is accountability. I would like to simply indicate that in January 2002, we made some 62,000 rating decisions. That is compared to 29,000 rating decisions for the previous January. So I think we are beginning to see the workload turn around. As new employees gain greater experience and as we are able to fit them into specialized teams so that we can use the appropriate experience they have to buildup expertise in particular areas, I think we will see increased productivity and a decline in the average number of days.

There is a great deal we can do in reducing cycle time processing. We now have inventory management systems in place which we can pinpoint how long it takes to get a claim under control; how long it takes to initiate development. I was astounded to find, for example, that getting a claim under control took an average of 30 days and that the average time for initiating development on a claim was close to 68 days. These are real opportunities to reduce processing time. We are watching this very closely through an inventory management system so that we can track the status of cases at the regional office, team, or individual employee level.

Chairman ROCKEFELLER. Gentlemen and ladies, thank you very, very much. Thank you for your patience, and thank you for your candor. Thanks, Tony.

Our second panel will be veterans service organizations. If I could have order, please. The gentleman on the right, please.

The second panel includes representatives of the independent budget, who will be introduced by Bob Jones, who is Executive Director of AMVETS; Richard Fuller, National Legislative Director, Paralyzed Veterans of America; Rick Surratt, Deputy Legislative Director, Disabled American Veterans; Paul Hayden, Associate Director of Legislation, VFW; and Rick Jones, Legislative Director, AMVETS; and here also is Jim Fischl, National Veterans Affairs and Rehabilitation Commission, the American Legion. We will start with Mr. Jones.

STATEMENT OF BOB JONES, NATIONAL EXECUTIVE DIRECTOR, AMVETS

Mr. BOB JONES. Mr. Chairman, thank you so very much for having us here this morning. Sir, I would request that my prepared testimony be entered into the official records, please.

Chairman ROCKEFELLER. That is always the case.

Mr. BOB JONES. Thank you, sir. Sir, I would like to thank you and Ranking Member Specter and the rest of the committee for their continuing invaluable support for the independent budget. As you are aware, this is the 16th year for the independent budget, and it has been endorsed by over 40 veteran, military, and medical associations.

We believe that the independent budget provides rational, rigorous and sound review of our veterans' needs. We believe that the VA is an excellent investment for America, and with proper resourcing, it is essential to maintain a well-functioning system. VA services should not suffer with unfunded mandates. We do not want to see the possibility of rationed health care in the future. The President expressed in his State of the Union support for an improved medical care program within the Department of Veterans Affairs, and we are pleased with that.

However, Mr. Chairman, we believe that the administration's proposed $22.75 billion for health care is approximately $1.75 billion lower than we in the independent budget organizations believe is required for maintaining that health care system. Yesterday, we heard from the Chairman of the House Veterans' Affairs Committee and Ranking Member Evans who pledged their opposition to the $1,500 deductible for Category 7s that has been proposed by the administration. We sincerely appreciate your comments of concern, and we hope that the Congress will overturn that administration proposal.

Sir, though the independent budget does not have a position concerning the transfer of VETS, we do have a position concerning the adequate resourcing and the outcomes of service delivery. I would like to stress that AMVETS as a national organization strongly opposes the transfer of the Veterans' Employment and Training Service from the Department of Labor to the Department of Veterans Affairs. We do believe that improved service delivery outcomes that are based on performance standards are absolutely critical, and we believe that the current proposal has been ill-defined and do not support that proposal.

Sir, with your concurrence, I would like to yield the rest of my time to my colleagues so that we can get to the core of the independent budget.

Chairman ROCKEFELLER. Certainly.

[The prepared statement of Mr. Bob Jones follows:]

PREPARED STATEMENT OF BOB JONES, NATIONAL EXECUTIVE DIRECTOR, AMVETS

Mr. Chairman, Ranking Member Specter, and Members of the Committee.

I am Mr. Bob Jones, Executive Director of AMVETS and Chairman of The Independent Budget for Fiscal Year 2003.

Thank you for the opportunity to be here today to present The Independent Budget, co-authored AMVETS, Disabled American Veterans, Paralyzed American Veterans and the Veterans of Foreign Wars. As you know, this is the 16th annual budget presented by our coalition, and we are proud that more than 40 veteran, military and medical service organizations endorse these recommendations. In whole, these recommendations provide Congress with a rational, rigorous and sound review of the budget required to support the vital programs for our nation's veterans.

In developing this document, we believe in certain guiding principles. Veterans must not be forced to wait for the benefits promised them. Veterans must be assured of access to high quality healthcare. Veterans must be guaranteed access to a full continuation of healthcare services, including long-term care. And, veterans must be assured burial in state or national cemetery in every state.

It is our firm belief that the mission of the VA must continue to include support of our military in times of emergency and war. Just as this support of our military is essential to national security, the focus of the VA medical system must remain centered on specialized care. VA's mission to conduct medical and prosthetics research in areas of veterans' special needs is critical to the integrity of the veterans healthcare system and to the advancement of American medicine.

In addition, it must be recognized that VA trains most of the nation's healthcare workforce. The VA healthcare system is responsible for great advances in medical science, and these advanced benefits all Americans. The VHA is the most cost effective application of federal healthcare dollars, providing benefits at 25 percent lower cost than other comparable medical services. In times of national emergency, VA medical services can function as an effective backup to the DoD and FEMA. In the State of the Union Address, the President stated his support for increased funding for VA healthcare services.

After mentioning the important mission of the VA, I must now point to the areas where VA funding must be increased. The VA budget must address the pending wage increases for VA employees. It must also address VA's large casework backlog. There are severely disabled veterans and those needing home-based healthcare in those backlogs and I think we can all agree that this situation should be reversed.

Without adequate funding, healthcare services may need to be rationed. The funding shortfall of the FY '02 budget, paired with continued open enrollment makes it very difficult for VA to provide quality healthcare in a timely manner.

On the administration's legislative proposal, we call on Congress to provide adequate funding to avoid implementation of the $1,500 deductible on priority seven veterans.

The bottom line Mr. Chairman is that VA is an excellent investment for America. Proper funding levels for the VA makes good fiscal sense to maintain a well functioning system. To this end, the administration must increase VA medical care funding to $24.5B for FY '03, an increase of $3 billion over last year's VA budget.

One more point that deserves comment is the proposed transfer of the Veterans Employment and Training Services (VETS) to VA. Clearly, VA has its own challenges with healthcare waiting lists and backlogs in claims processing. VA is ill prepared to accept a program, which is so naturally suited to the Department of Labor (DOL). DOL has the departmental knowledge regarding the job-market. It knows where the jobs are and the skill required to fill them. Shifting VETS from one department to another is not a "magic bullet," and it will not serve veterans better. Now is not the time to cut VETS programs from DOL.

Mr. Chairman, this concludes my remarks. I will now introduce the gentleman who will testify to specific recommendations of The Independent Budget for FY '03. Rick Surratt, representing the Disabled Americans Veterans, will brief you on The Independent Budget's benefits priorities. Harley Thomas, of the Paralyzed Veterans of America, will address the vital needs in the VA healthcare system. Fred Burns, of the Veterans of Foreign Wars, will inform you of the critical problems of the VA's

infrastructure and construction needs, and Rick Jones, of AMVETS, will offer you The Independent Budget concerns regarding our nation's veterans cemeteries.

STATEMENT OF RICHARD FULLER, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. FULLER. Good morning, Mr. Chairman. I am Richard Fuller, National Legislative Director of Paralyzed Veterans of America. I am sitting in today for our Deputy Executive Director, Mr. John Bollinger.

As we have for the past 16 years, Paralyzed Veterans of America is once again pleased to be responsible for the health care recommendations and analysis for the Department of Veterans Affairs, Veterans Health Administration budget. I shall address these today in my testimony. For fiscal year 2003, "The Independent Budget" recommends a medical care appropriation of $24.468 billion. That is an increase of $3.1 billion over fiscal year 2002. This proposed increase does not assume any new initiatives or work load increases.

Over the last 5 years, the VA has served a constantly growing number of veterans with appropriations that have steadily declined in purchasing power. The fiscal year 2001 health care appropriation was $564 million short of the amount recommended by "The Independent Budget," and the fiscal year 2002 budget falls $1.5 billion short. Already a few months into fiscal year 2002, the administration has reported a shortfall of close to $500 million and is seeking supplementary funding, which is a step we fully support.

Nationally, Mr. Chairman, we are witnessing an explosion in health care costs, especially in pharmaceutical costs, which have been discussed today. The VA has not been immune to this trend, even though it does purchase pharmaceuticals at discount rates. According to a report from the Department of Health and Human Services, national health care spending increased 6.9 percent in the year 2000, and the fastest-growing segment of health care spending is, of course, prescription drugs, which increased 17.3 percent in 2000.

This represents the sixth consecutive year of double-digit increases in pharmaceutical costs. Spending on prescription drugs has doubled between 1995 and 2000 and has tripled between 1990 and 2000. VA health care budgets have not kept pace with this explosive spending growth. The real effect of inadequate health care appropriations is felt by sick and disabled veterans every day, and inadequate appropriations force the VA to ration care by lengthening waiting times and delaying services.

As has been discussed here this morning, when you subtract all of the window dressing from the administration's budget, the administration has proposed a medical care appropriation of $22.7 billion, an increase of only $1.4 billion over fiscal year 2002. Although veterans appreciate any increase, we are also cognizant of the fact that this does not meet the needs of the VA in the coming fiscal year and does not provide the resources necessary to ameliorate the recent effects of inadequate appropriations.

Again this year, Mr. Chairman, we have not included collections as part of our recommendations concerning appropriated dollars. As we state in "The Independent Budget," we recognize that non-

appropriated funding may be available to expand VHA operations and ultimately improve care for veterans, but we are strongly committed to the principle that the cost of VA health care is a Federal responsibility that must be met in full by Congress and the administration through adequate appropriations. VA must not be forced to rely on subsidies from veterans or their insurance to cover the cost of caring for veterans, and veterans must not be held hostage through collection estimates that very well may be far-fetched or issued solely to cover budgetary holes left by inadequate appropriations or other budget requests.

As discussed earlier as well, "The Independent Budget" is opposed to the administration's proposal to begin charging a $1,500 deductible for health care for Category 7 veterans. The only reason, I believe we would concur with you, Mr. Chairman, for the imposition of a deductible requirement is not to raise money, but is just a means of discouraging currently eligible veterans from seeking VA health care. Last year, the administration announced that it would continue to enroll Category 7 veterans, and it said that it would find the money someplace. But instead of finding the additional resources, it has proposed to have veterans pay for this care out of their own pockets or disenroll themselves.

The VA itself estimates that a deductible will deter 121,000 veterans from seeking health care. Requiring the deductible could adversely affect lower-income veterans, veterans whose insurance will not pay the deductible and who want and need to go to the VA.

I would just like to, in closing, Mr. Chairman, say that "The Independent Budget" fully concurs with the comments that were made here about the VA's role in homeland defense. The Secretary requested $250 million last year. That was the estimate he gave. We strongly believe that potentially, that could be part of a supplemental appropriation going through the Congress. The VA has an enormous role to play.

We would also like to underscore our support for the VA research program. VA research needs consistent and steady funding from year to year and not funding ups and downs and ups and downs. "The Independent Budget" recommends $460 million for VA research, which is an increase of $89 million over fiscal year 2002.

That concludes my part of the testimony, Mr. Chairman.

[The prepared statement of the Paralyzed Veterans of America follows:]

PREPARED STATEMENT OF JOHN C. BOLLINGER, DEPUTY EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. Chairman, Ranking Minority Member Specter, members of the Committee, the Paralyzed Veterans of America (PVA) is honored, on behalf of our members and the Independent Budget, to present our views on the Department of Veterans Affairs' (VA) budget for fiscal year (FY) 2003. We are proud to be one of the four coauthors, along with AMVETS, the Disabled American Veterans, and the Veterans of Foreign Wars, of the 16th Independent Budget, a comprehensive policy document created by veterans for veterans.

The Independent Budget is an annual budget and policy review for veterans programs and represents an unprecedented joint effort by the veterans' community to identify the major issues facing the veterans' community today while serving as an independent assessment of the true resource and policy needs facing veterans. As we have for the past 16 years, it is our distinct pleasure, once again, to be responsible for the health care recommendations and analysis, and I shall address these in my testimony today.

For FY 2003, the Independent Budget recommends a medical care appropriation of $24.468 billion, an increase of $3.1 billion over FY 2002. This proposed increase does not assume any new initiatives or workload increases. Unfortunately, we are seeing the effects of an inadequate budget for FY 2002, a budget that we estimate to be $1.5 billion less than the amount required. To address this shortfall, and to provide for the current services requirements of the VA, the Independent Budget has requested this $3.1billion increase.

This amount is a realistic assessment of what the VA must have in order to meet its obligations, both statutorily and morally. This recommended increase addresses the "current services" requirements of VA health care for FY 2003, while recognizing the cumulative funding shortfalls faced by the system over the last two years.

Over the last five years, the VA has served a constantly growing number of veterans with appropriations that have steadily declined in purchasing power. The FY 2001 health care appropriation was $564 million short of the amount recommended by the Independent Budget, and the FY 2002 budget falls $1.5 billion short. Already, a few months into FY 2002, the Administration has reported a shortfall of close to $500 million, and is seeking supplementary funding, a step we fully support.

Nationally, we are witnessing an explosion in health care costs, especially in pharmaceutical costs. The VA has not been immune to this national trend. According to a report from the Department of Health and Human Services, national health care spending increased 6.9 percent in 2000. The fastest growing segment of health care spending is prescription drugs, which increased 17.3 percent in 2000. This represents the sixth consecutive year of double-digit increases. Spending on prescription drugs has doubled between 1995 to 2000, and has tripled between 1990 and 2000. VA health care budgets have not kept pace with this explosive spending growth.

The real effect of inadequate health care appropriations is felt by sick and disabled veterans every day. Inadequate appropriations force the VA to ration care by lengthening waiting times and delaying services.

The Administration has proposed a medical care appropriation of $22.744 billion,[1] an increase of $1.4 billion over FY 2002. Although veterans appreciate any increase, we are also cognizant of the fact that this does not meet the needs of the VA in the coming fiscal year, and does not provide the resources necessary to ameliorate the effects of recent inadequate appropriations. Unless additional resources are provided, the current situation, as intolerable as it is, will continue into the foreseeable future, and sick and disabled veterans will once again be shortchanged by the very government they have served, and rely upon to care for them.

Again, we note that the Administration's budget relies upon "management efficiencies" to address real budgetary needs. It seems that every year "management efficiencies" are a handy way of making the budgets seemingly balance. As the Independent Budget states, "there are no more 'efficiencies' to be wrung out of the system. For the last five years, VHA [Veterans Health Administration] has served a constantly growing number of veterans with appropriations that have been steadily declining in purchasing power."

Again this year we have not included collections as part of our recommendations concerning appropriated dollars. As we state in the Independent Budget, we recognize "that nonappropriated funding may be available to expand VHA operations and ultimately improve care for veterans, we are strongly committed to the principle that the cost of VA health care is a federal responsibility that must be met in full by Congress and the Administration through adequate appropriations. VA must not be forced to rely on subsidies from veterans or their insurers to cover the costs of caring for veterans." Veterans must not be held hostage through collection estimates that very well may be far-fetched or issued solely to cover budgetary holes left by inadequate appropriations.

The Independent Budget is opposed to the Administration's proposal to begin charging a $1500 deductible for health care for category 7 veterans. The primary reason we can see for the imposition of a deductible requirement is to discourage currently eligible veterans from seeking VA health care. Recently, the Administration announced that it would continue enrolling category 7 veterans. It said that it would find the resources to cover the costs of these health care services. Instead of providing the additional resources, it has proposed to have veterans pay for this care out of their own pockets. The VA itself estimates that a deductible will deter 121,000 veterans from seeking health care. Requiring a $1500 deductible could ad-

[1] We have subtracted, from all Administration requests, amounts attributable to the legislative proposal put forth by the Administration that would include accrual costs for pension and post-retirement benefits for federal retirees. For medical care, this figure is estimated to be $793 million for FY 2003.

versely affect lower-income veterans, veterans whose insurance will not pay the deductible, and who want and need to go to the VA particularly to provide services they cannot find elsewhere in the private sector or on Medicare, for instance long-term care, prescription drugs, or specialized services. Finally, we are concerned about the perverse disincentive that this deductible scheme could have on veterans who represent the core mission of the VA. The Independent Budget proposal fully covers the cost of providing care for these category 7 veterans.

We are very concerned that the Administration has failed to provide funding for the VA to meet its critical fourth mission—to serve as a backup to the Department of Defense in times of war or national emergency. The VA is also a critical component of the federal government's emergency response capabilities, and an integral part of our national homeland defense efforts. Headlines read "Bush's Budget Doubles Homeland Funds," and "Bush to Request Big Spending Push on Bioterrorism," but there are no resources made available to the VA. As the Washington Post reports, "while police and firefighters, border security agents, bioterrorism experts and intelligence agencies understandably were among the biggest winners in the new budget—which contains nearly $38 billion for domestic security activities—agencies that once had only the most remote links to homeland security would be showered with funds for that purpose." Pianin and Miller, "Security Permeates Budget," Washington Post, February 5, 2002, A7. But the VA has been forgotten.

This national emergency entails not only a crisis abroad, but a crisis here at home. As the VA serves as a backup to our Armed forces, it also serves as a backup to, and an integral part of, our Nation's health care system. When terrorists struck New York City, the VA was there, caring for victims. In fact, the Government Accounting Office, in its January 2001 report entitled "Major Management Challenges and Program Risks" (GAO–01–255) characterizes the VA's role as the "primary backup to other federal agencies during national emergencies." The VA must be prepared, and provided with the resources it needs, to accomplish this comprehensive and vital mission.

Taking its lead from requirements detailed in Congressional testimony by Secretary Principi, the Independent Budget has requested $250 million to meet its duties in this area.

The stresses on the VA system will only become more severe. The VA plays an indispensable role as part of the federal commitment to states and local communities in times of national emergency and disaster. The VA does not have the resources to meet its responsibilities to sick and disabled veterans, and the Independent Budget fears that the VA will not be able to fulfill its important responsibilities under this critical fourth mission.

The Independent Budget has recommended an increase for Medical Administration and Miscellaneous Operating Expenses (MAMOE) of $9 million, bringing this account up to $76 million. The Administration has requested $70 million, an increase of only $3 million. Funding shortfalls in the MAMOE account have left the VA unable to adequately implement quality assurance efforts or to provide adequate policy guidance within the 22 Veterans Integrated Service Networks (VISN). Veterans Health Administration headquarters staff play the essential role of providing leadership, policy guidance, and quality assurance monitoring under the decentralized VA health care system. It is important that these important roles be strengthened.

Although VA Medical and Prosthetic Research has not suffered the same budget pressures that have beset health care, it is still suffering from the uncertainty it faces each budget cycle. Research, which is essential to VA's continuing partnerships with medical schools and universities, requires a long-term commitment and stable, reliable funding. This needed stability is undermined by the annual budget game, where the Administration submits an unreasonably low budget for this vital program and relies upon Congress to partially redress the shortfall. This has a direct impact upon the research community, hampering its planning and funding decisions as it tries to adjust to this yearly funding whiplash. This game must stop. VA research must receive consistent and adequate budget increases in order to keep pace with our national research effort. For FY 2003, the Independent Budget recommends an appropriation of $460 million, an increase of $89 million over FY 2002.

The Administration has proposed $394 million for VA research, an increase of $23 million over the amount provided in FY 2002, but a full $66 million below the $460 million recommended by the Independent Budget.

We recognize that this Committee does not appropriate dollars, but you do authorize them. You serve as a resource, and as advocates, to the appropriators as they fashion budgetary policy. The authorization process must recognize the real resource requirements of the VA. We look to you, and your expertise in veterans' issues, to help us carry this message forward, to your colleagues and to the public.

The VA is facing a crucial hour in a critical time. As a Nation we must not forget the sacrifices, and the service, of the men and women who served on the ramparts of freedom. If we provide inadequate budgets we are sending a clear message concerning what we value as a society. Let us make sure that the message we send is consistent with what we believe ourselves to be.

We need your help, and we offer our assistance, to ensure that the VA receives the funding it needs to ensure that veterans receive the health care they have earned, and the health care they have been promised. Let us move forward from our accomplishments of the last couple of years and build a strong, and continuing base, for the national asset that is the VA.

On behalf of the co-authors of the Independent Budget, I thank you for this opportunity to testify concerning the resource requirements of VA health care for FY 2003. I will be happy to answer any questions you might have.

Chairman ROCKEFELLER. Thank you.

STATEMENT OF RICK SURRATT, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. SURRATT. Mr. Chairman, good morning. I am Rick Surratt with the DAV. I will focus on the benefit programs, the DAV's primary area of responsibility in the independent budget. Other than permanent authority for income-matching between the agencies for pension purposes, the President's budget includes only one legislative proposal for the benefit programs, and that is for an annual compensation COLA. In addition to recommending a COLA to keep compensation in line with the increase in the cost of living, the IB makes a number of recommendations to improve the benefit programs.

Last year, you enacted several of the things recommended by the IB, and we appreciate that. In this year's IB, we have identified other areas where we think the benefits need changes to make them better or more equitably serve veterans. I will not cover those several recommendations here, but we hope you will give them careful consideration.

Of course, the President's budget includes no funding to cover the cost of these improvements, and that is always an issue for this committee. No matter how carefully the benefit programs are crafted, they lose effectiveness if they are not administered well. If claims are not decided correctly, and benefits are not delivered timely, veterans suffer, especially veterans seeking compensation to make up for the economic losses caused by service-connected disabilities and impoverished veterans, totally disabled veterans seeking pensions.

VA has struggled unsuccessfully for years to overcome serious deficiencies in its processing of compensation and pension claims. There is no longer any question about the magnitude of the problem. The question is whether VA has the will and the resolve to take the necessary steps to correct the problem. In the context of the budget, there is a question of whether VA must have additional resources to enable it to gain control over its quality problems and its enormous volume of long-pending claims. The IB has recommended to the VA that it concentrate its focus first on solving the root causes of its claims processing problems. We have identified those root causes as inadequately trained adjudicators or lack of accountability for proper actions and legally correct claims decisions and management weaknesses.

The IB observes that VA's repeated failures to successfully overcome its claims processing problems stem from its failure to tackle the toughest problems, that is, the root causes and stay the course until those problems are resolved.

Chairman ROCKEFELLER. What are the toughest problems you've identified?

Mr. SURRATT. Well, it is quality, and quality stems somewhat from resources and from a lack of accountability and a lack of strong management, and the quality, in turn, causes rework and overburdens in an already heavily loaded system.

VA must also resist its self-defeating tendency to rush decision-making to reduce its claims backlog only to rework a substantial portion of these cases because of errors and add to the volume of work and ultimately to the backlog. While the IB agrees with the argument that VA must get more serious about implementing meaningful reforms and follow through until those reforms are fully achieved, we do not agree with the convenient suggestion that VA needs no increase in staffing to accomplish this. To allow it to take the necessary steps to properly train its work force and monitor quality without reducing the number of employees working on pending claims, VA still needs to increase staffing in its claims processing system.

VA cannot succeed without properly training those who decide claims and without enforcing quality standards. With the large volume of pending claims, VA must at the same time maintain full claims processing capacity. The IB, therefore, recommends that 350 additional FTE be authorized for VA's Compensation and Pension Service. The President's budget seeks only 96 additional employees for C&P.

Even with the very best administrative process, mistakes are inevitable in a mass adjudication system like VA's. That is why an effective judicial review process is essential to ensure that veterans receive the benefits to which they are entitled. The IB has made three recommendations to improve judicial review in veterans benefits matters, and we hope this committee will take action on these recommendations this year.

Mr. Chairman, let me now turn to the $1,500 medical deductible scheme to make a point. It is a sad day when VA's new mission is to drive veterans away from the system. Regrettably, that tactic is not new to the benefits area. VA's new regulations these days seem designed to freeze veterans out of the system. VA attempts to inhibit what it cannot prohibit. The DAV and other veterans' organizations have begun to challenge VA regulations more frequently in court; in fact, it is becoming commonplace because of that reason. We hope this committee will work with us to ensure VA maintains its mission of service to veterans.

Mr. Chairman, that concludes my statement. Thank you for allowing us to come before you today to offer our views on the fiscal year 2003 budget.

[The prepared statement of Mr. Surratt follows:]

PREPARED STATEMENT OF RICK SURRATT, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman and Members of the Committee:

Representing the Disabled American Veterans (DAV) as a participant in The Independent Budget (IB), I am pleased to appear before you to discuss the President's fiscal year (FY) 2003 budget proposal for the Department of Veterans Affairs (VA). The budget is, of course, a matter of paramount importance to the more than one million disabled veterans who are members of our organization and to the members of our Women's Auxiliary. The effectiveness of essentially all veterans' programs—and therefore the welfare of veterans and their families—is dependent upon full funding for the benefits and services and resources adequate to allow for their timely, efficient delivery.

Joining with AMVETS, the Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars of the United States (VFW), the DAV incorporates its annual recommendations for funding of veterans' programs, and many of its legislative and policy proposals, in the IB. With the shared goal of ensuring that the needs of America's veterans are adequately addressed, the four organizations pool their resources and work together to assess and present the budgetary requirements and related issues facing veterans' programs.

Each of the four organizations takes primary responsibility for selected portions of the IB. Here, I will focus on Benefit Programs, General Operating Expenses (GOE), and Judicial Review in Veterans' Benefits, the DAV's assigned areas of the IB. The members of the IB group appreciate the courtesy this Committee has extended in permitting us to present our views together in this format.

The President's total budget of $58 billion includes nearly $1.5 billion VA projects it will realize by offset from medical care collections, $892 million to pay a newly assumed obligation to fund employee health care and retirement costs, and $197 million for a new grant program for veterans' employment services to replace those veterans' employment programs now administered by the Department of Labor. The $58 billion in budget authority for VA includes $29.6 billion for the benefit programs and $1.3 billion for GOE. Within the GOE appropriation, the President's budget would provide $1.2 billion for the delivery of benefits in the Veterans Benefits Administration (VBA) and $278 million in budget authority for General Administration.

For the benefit programs, the President's budget includes funding for its legislative recommendation to increase compensation, which includes dependency and indemnity compensation and the clothing allowance, to meet a projected increase in the cost of living of 1.8% this year. The IB also recommends a cost-of-living adjustment (COLA) for these benefits and urges Congress not to extend provisions for rounding down the compensation COLA beyond the current sunset date.

Regrettably, the President's budget does not propose any other improvements to compensation and related benefits, readjustment benefits, or insurance programs. For these benefit programs, the IB makes the following recommendations for legislation:

- to exclude compensation from countable income for Federal Programs
- to repeal the prohibition of service connection for disabilities related to tobacco use
- to authorize a presumption of service connection for noise-induced hearing loss and tinnitus suffered by combat veterans and veterans who had military duties with typically high levels of noise exposure
- to repeal delayed beginning dates for payment of increased compensation based on temporary total disability
- to authorize payment of fees under the Equal Access to Justice Act (EAJA) to nonattorneys who represent appellants before the United States Court of Appeals for Veterans Claims
- to authorize refund of contributions to veterans who become ineligible for the Montgomery GI Bill by reason of discharges characterized as "general" or "under honorable conditions"
- to increase the amount of the specially adapted housing grants and to provide for automatic annual adjustments for increased costs
- to provide a grant for adaptations to a home that replaces the first specially adapted home
- to increase the amount of the automobile grant and to provide for automatic annual adjustments for increased costs
- to exempt the dividends and proceeds from and cash value of VA life insurance policies from consideration in determining entitlement under other Federal programs
- to authorize VA to use modern mortality tables instead of 1941 mortality tables to determine life expectancy for purposes of computing premiums for Service-Disabled Veterans' Insurance
- to increase the face value of Veterans' Mortgage Life Insurance

• to repeal the 2-year limitation on payment of accrued benefits
• to protect veterans' benefits from unwarranted court-ordered awards to third parties in divorce actions

The IB also recommends legislation to remove the offset between military retired pay and disability compensation and legislation to extend the 3-year limitation on recovery of taxes withheld from disability severance pay and military retired pay later determined exempt from taxable income.

The coauthors of the IB carefully identify areas in the benefit programs that need adjustment or improvement to make the benefits more effectively or equitably fulfill the purposes for which Congress established them. Last year, Congress enacted legislation that addressed several IB recommendations. We appreciate your action on these matters. Although it is in a position to know where beneficial legislative changes could better serve our Nation's veterans, the Administration has not taken the lead in recommending legislation to improve veterans' programs. Therefore, if meritorious improvements are to be made, the members of this Committee must initiate action on them. In developing your legislative agenda this year, we ask that you again give thorough consideration to the recommendations we have included in this year's IB.

Unlike the lack of positive recommendations in the budget to improve the benefit programs, VA Secretary Principi has made improving VA's administration of the benefit programs, especially compensation and pension claims processing, one of his foremost priorities. We are confident of his sincerity and determination on this issue. We have not seen great progress in this area to date, however, and despite this budget's stated focus on improving claims processing, it does not request resources to match actions with words.

Although the President's budget recommends a $94-million increase in funding for VBA under the GOE account, $53.9 million of that would cover a new obligation to fund employees' retirement and health benefits. With the net increase of $40.2 million above last year's funding, the increase for VBA is approximately 3.6%, which is well below the average increase of approximately 10% requested by the President over the past 5 years. The President's budget recommends only 96 additional employees for compensation and pension (C&P) service. Within this budget, VA promises to reduce the average time for rating actions on C&P claims from 208 days to 100 days in the last quarter of FY 2003, while improving training for claims processors and increasing the accuracy rate for core rating work from 78% in FY 2001 to 88% in FY 2003. Other initiatives in C&P include:

• begin to transition from a paper-based to an electronic claims record
• consolidate pension cases in three pension centers
• continue the implementation of four new training and support systems for adjudicators
• analyze the needs of the C&P claims development and adjudication process and design a new system known as C&P Evaluation Redesign (CAPER)
• deploy an individual performance assessment program to measure and enforce employee proficiency, known as the Systematic Individual Performance Assessment (SIPA)
• pursue development of a modern system to replace the existing benefit payment system
• expand the Veterans On-Line Application program, which allows veterans to apply for benefits over the Internet

While improved processes, new technology, better training, and real accountability for legally correct decisions—if properly, timely, and completely implemented—will enable VA to eventually increase efficiency and overcome its intolerable claims backlog, VA still needs additional employees for C&P in the short term. Training new employees, retraining VA's existing workforce, and conducting quality reviews of the work of individual adjudicators will require substantial numbers of employees who will not be devoted to production and reducing the backlog. We believe the President's request for only 96 additional employees for C&P is tied more to budget targets than to the real needs of VA. The IB recommends funding for 350 additional employees in C&P Service. Additionally, based on unofficial estimates, the IB recommends $4.5 million, instead of the $2 million requested in the President's budget, to fund CAPER.

Unless VA makes other reforms in management and takes a more direct and decisive approach to tackling the claims backlog, it is likely to continue to fail in its efforts to make meaningful improvements in the accuracy and timeliness of its claims processing. Currently, the head of VA's C&P service and VBA's other program directors do not have management authority over their employees in VA field offices. The C&P director is powerless to enforce quality standards and C&P policy. Higher-level officials in VA's Central Office are more removed from and do not have

the daily hands-on experience that the C&P director has in the C&P programs. The IB recommends that the C&P director and other VBA program directors be given line authority over field offices to strengthen VBA's management structure and allow for more effective enforcement of quality and performance standards.

Those who have witnessed C&P's repeated failures to overcome its claims processing deficiencies know that those failures involve repetitive patterns in which VA develops plans but fails to follow through with decisive steps to solve the difficult problems. VA attempts to overcome its serious deficiencies by fine-tuning its procedures and employing new technology. While those efforts may aid in improving claims processing, alone or in combination they are not enough to enable VA to overcome its longstanding problem. The coauthors of the IB believe that it is obvious VA must resolve to focus primarily on eliminating the root causes of its claims backlog if it is to ever succeed in restoring the system to acceptable levels of performance and service. As noted, we believe that adequate resources are key to the effort. However, VA's adjudicators make erroneous decisions because they have not been properly trained in the law, they have operated in a culture that tolerated indifference to the law, and they have not been held accountable for poor performance and proficiency. Accordingly, in conjunction with the deployment of better training, VA must take bold steps to change its institutional culture, and it must make its decisionmakers and managers truly accountable.

If VA's ambitious goal of improving timeliness takes precedence over its goal of improving quality, VA will merely repeat the failures of the past. Speeding up the process with the single goal of reducing claims processing times and claims backlogs is self-defeating if, because quality is compromised, a substantial portion of the cases must be reworked. In this respect, VA has shown some inability to learn from its past mistakes.

VA has made similar mistakes in its efforts to avoid meeting some of the obligations Congress has imposed upon it and in its efforts to avoid fully implementing legislation enacted by Congress. In exploiting an erroneous line of decisions by the courts to avoid its duty to assist claimants in developing and prosecuting claims, VA made additional work for itself in the end because it had to rework thousands of these claims after Congress intervened and restored the duty to assist. Several veterans' organizations have now challenged in court VA's rules to implement this legislation. While courts tend to indulge agencies in rulemaking, the veterans' organizations challenging the validity of VA's regulation in this instance have a high level of confidence about the prospects for having VA's regulations set aside because of their clearly arbitrary nature and conflict with the law. If the Court of Appeals for the Federal Circuit finds that VA's regulations do not fulfill the mandates of the law, VA may once again be saddled with the task or reviewing thousands of cases to apply the law properly. These self-inflicted setbacks complicate VA's efforts to overcome its claims backlog. In this vein and because of the adverse effects upon veterans' rights, the IB has urged the VA Secretary to reform his department's rulemaking. Court challenges to what is viewed as self-serving VA rules are becoming commonplace.

Under the VBA portion of the GOE appropriation, the IB also includes a recommendation to fund new information technology for VBA's Education Service. Administration of VA's education programs involves the routine exchange of massive amounts of data between educational institutions and VA. This routine exchange of correspondence and data is particularly well suited to automated systems, which can greatly reduce personnel costs and processing times. The IB therefore recommends that Congress provide $16 million for upgrading and expanding the limited application and capabilities of the existing system. For this VA initiative, known as The Education Expert System (TEES), the President's budget requests only $6.3 million. Again, information not revised to meet the objectives of the Administration's budget process indicates that $16 million is the real funding level needed for this project.

The President's budget proposes legislation to establish a new program in VBA for providing grants to states for employment and training services for veterans. This new VA program would replace the veterans' employment and training services of the Department of Labor. The IB has taken no position on this issue, but the DAV and other veterans' organizations have mandates from their membership to oppose the transfer of veterans' employment and training services to VA from the Department of Labor. The President's proposal raises many questions about the nature and effectiveness of such a program. When the details of this proposal are made available, the IB will give it additional consideration.

The President's budget request would reduce the number of employees authorized for the Board of Veterans' Appeals (BVA) from 464 to 451. The caseload at the Board is temporarily down because VA regional offices have directed their resources

to reducing the backlog of claims and neglected work on their appellate workload. However, new VA regulations recently assigned BVA the added responsibility for correcting the regional offices' failure to obtain all necessary evidence. Eventually, VA regional offices must resume work on their pending appeals, and BVA will begin receiving large numbers of appeals that have been allowed to accumulate in regional offices. Many of VA's problems stem from improvident reductions in staff in the face of impending increases in workload. We therefore recommend caution in considering any reduction in BVA's workforce at this time.

In enacting legislation in 1988 to authorize veterans to challenge VA decisions in court, Congress recognized the importance of the right to have VA's decisions reviewed by an independent body. Judicial review has had the beneficial effect of exposing administrative departure from the law and forcing reforms within VA. However, the judicial review process needs some adjustments itself to make it serve veterans in the manner envisioned by Congress.

The IB recommends legislation to change the standard under which the Court of Appeals for Veterans Claims (CAVC) reviews VA's findings of fact in claims decisions. The current "clearly erroneous" standard conflicts with and undermines the benefit-of-the-doubt rule. Under the statutory benefit-of-the-doubt rule, VA is mandated to resolve factual questions in the veteran's favor unless the evidence against the veteran is stronger than the evidence for him or her. However, CAVC will uphold a VA decision if there is any evidence to support it, and this renders the benefit-of-the-doubt rule unenforceable.

Currently, VA regulations, with the exception of provisions in the Schedule for Rating Disabilities, are subject to challenge in the Court of Appeals for the Federal Circuit (CAFC). The IB recommends expanding CAFC jurisdiction to permit it to review challenges to the validity of the rating schedule on the narrow basis of whether the rating is contrary to law or is arbitrary and capricious. The coauthors of the IB believe that no unlawful or arbitrary and capricious rating schedule provision should be immune to review and correction.

The jurisdiction of CAFC is restricted in another manner that does not serve the cause of justice well. While CAFC has jurisdiction to consider an appeal that involves a dispute about the proper interpretation of a law or regulation, it has no jurisdiction to consider an appeal that involves a dispute about the proper application of the law to the facts in a case. The IB recommends that CAFC jurisdiction be expanded to cover these so-called ordinary questions of law.

Much of what this Committee will seek to accomplish on behalf of veterans this year will be subject to what Congress appropriates for veterans' programs. We urge the Committee to press for a budget that is adequate for existing programs and allows for some improvement in benefits and services for veterans. We hope our independent analysis of the resources necessary for veterans' programs and our legislative and policy recommendations are helpful to you, and we sincerely appreciate the opportunity to present our views and recommendations to the Committee.

Chairman ROCKEFELLER. Thank you, Rick. I hope the committee tries to maintain its commitment to veterans also.

Please.

STATEMENT OF PAUL HAYDEN, ASSOCIATE DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

Mr. HAYDEN. Mr. Chairman, on behalf of the 2.7 members of the Veterans of Foreign Wars of the United States and its Ladies' Auxiliary, I would like to thank you for the opportunity to participate in today's hearing. The VFW's primary contribution as a member of the Independent Budget is an analysis of the Department of Veterans Affairs' construction programs. Therefore, as in years past, I will confine my remarks to this particular area of the VA budget.

As this committee is well aware, VA possesses an immense, aged infrastructure that is in need of urgent funding. Your colleagues in the House of Representatives acted during the First Session of the 107th Congress to arrest the shortfall in VA construction funding by passing H.R. 811, the Veterans Hospital Emergency Repair Act. The Independent Budget was pleased to endorse this bill, and we

respectfully request this committee to favorably report this much-anticipated legislation to the full Senate without further delay.

The administration is requesting $194 million for major construction, up $11 million over fiscal year 02 funding, while funding for minor construction remains nearly flatlined at $211 million. An $11 million increase is hardly sufficient to sustain and improve nearly 1,300 care facilities, including 163 hospitals, 800 ambulatory care and community-based outpatient clinics, 206 counseling centers, 135 nursing homes and 43 domiciliary facilities. In fact, VA's capital assets value is in a constant state of deterioration. For nearly 5 years, we have cited an independent study conducted by Price Waterhouse that concluded VA should be investing an amount equal to 2 to 4 percent of its facilities to maintain and another 2 to 4 percent to improve them. In other words, VA should be investing roughly a minimum of $700 million annually on just upkeep.

Yet, a quick analysis of VA's construction budget since the 1998 study was published show us that VA received an average of $291 million a year for both major and minor construction since fiscal year 99, and if we figure in the fiscal year 03 proposal, it would bring that 5-year average to a mere $314 million. These figures represent less than half the recommended investment and have forced VA to delay high priority projects and other renovations to meet basic patient safety standards.

Realizing that restructuring could reduce budget pressures or generate revenues that could be used to enhance veterans health care benefits, we continue to be supportive of VA's capital assets realignment for enhanced services, or the CARES process. We note that CARES remains behind schedule, while needed construction is being held hostage. The independent budget recommends that VA immediately identify all of the facilities that will certainly be retained and allow construction of already-approved and/or urgently needed projects to improve patient safety and environment.

As always, stakeholders need to be included and consulted in every step of the process. Of great concern to the Independent Budget is that veterans and staff continue to occupy high-risk buildings. For example, 1 year after experiencing a 6.8 magnitude earthquake, the American Lake VA Medical Center and the State of Washington has yet to receive a dime for structural repairs to its main hospital and nursing home.

In order for VA to properly operate, maintain and improve its facilities, the Independent Budget recommends a minimum of $800 million for major and minor construction projects for fiscal year 03. For major construction, we recommend that Congress appropriate $400 million, $217 million higher than fiscal year 02. We have also recommended $400 million for VA's minor construction account. This represents an increase of $190 million. This increase will support construction projects for inpatient and outpatient care support, infrastructure and physical plant improvements, research, infrastructure upgrades and a historic preservation grant program to protect VA's most important historic buildings.

In order for VA to more effectively carry out these projects, we also recommend raising the ceiling on minor construction projects from the current $4 million per project to $16 million per project.

Mr. Chairman, this concludes my statement, and I will be pleased to answer any questions you or members of the committee may have.

[The prepared statement of Mr. Hayden follows:]

PREPARED STATEMENT OF PAUL HAYDEN, ASSOCIATE DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

Mr. Chairman and members of the Committee:

On behalf of the 2.7 million members of the Veterans of Foreign Wars of the United States (VFW) and its Ladies Auxiliary, I would like to thank you for the opportunity to participate in today's hearing. The VFW's primary contribution as a member of the Independent Budget is an assiduous analysis of the Department of Veterans Affairs' (VA) construction programs. Therefore, as in years past, I will confine my remarks to this particular area of the VA budget.

As this committee is well aware, VA possesses an immense, aged infrastructure that is in need of urgent funding. Your colleagues in the House of Representatives acted during the first session of the 107th Congress to arrest the shortfall in VA construction funding by passing

H.R. 811, Veterans Hospital Emergency Repair Act. The Independent Budget was pleased to endorse this bill, however, we are concerned by the inaction of this committee to address this important legislation that has been in your possession since March 28, 2001. We respectively request this Committee to favorably report this much anticipated legislation to the full Senate without further delay.

Unhappily, we again find that VA's budget request for fiscal year (FY) 2003 as it pertains to construction programs is inadequate. The administration is requesting $194 million (numbers are rounded up or down) for major construction, up $11 million over FY 2002 funding, while funding for minor construction remains nearly flatlined at $211 million. An $11 million increase is hardly sufficient to sustain and improve nearly 1,300 care facilities, including 163 hospitals, 800 ambulatory care and community-based outpatient clinics, 206 counseling centers, 135 nursing homes, and 43 domiciliary facilities.

In fact, VA's capital asset value is in a constant state of deterioration. For nearly five years we have cited an independent study conducted by Price Waterhouse that concluded VA should be investing an amount equal from 2 to 4 percent of the value of its facilities to maintain (nonrecurring maintenance) and another 2 to 4 percent to improve them. That means VA should be investing roughly a minimum of $700 million annually on just upkeep. Yet a quick analysis of VA's construction budgets since the 1998 study was published show us that VA received an average of $291 million a year for both major and minor construction since FY 1999; and if we figure in the FY 2003 proposal, it would bring the five-year average to $314 million. These figures represent less than half the recommended investment and have forced VA to delay high priority projects and other renovations to meet basic patient safety standards.

Recognizing that VA has undergone a major transformation in its health care delivery process (primarily inpatient-based to outpatient-based) and noting a Government Accounting Office (GAO) report that "without major restructuring, billions of dollars will be used in the operation of hundreds of unneeded VA buildings" and "restructuring" could reduce budget pressures or generate revenues that could be used to enhance veterans' health care benefits' we continue to be supportive of VA's Capital Assets Realignment for Enhanced Services (CARES) process.

We note that CARES remains behind schedule while needed construction is being held hostage. The Independent Budget recommends that VA immediately identify all the facilities that will certainly be retained and allow construction of already approved and/or urgently needed projects to improve patient safety and environment. Further, property divestures should be placed on hold until a comprehensive capital assets plan is formulated. As always, stakeholders need to be included and consulted in every step of the process.

Of great concern to the Independent Budget is that veterans and staff continue to occupy high-risk buildings. We have identified and expanded our list to 73 facilities that are subject to collapse or serious structural damage from an earthquake. We commend VA for funding seismic corrections in four of its California-based facilities in its FY 2003 budget request. We, however, remain perplexed that one year after experiencing a 6.8 magnitude earthquake, the American Lake VA Medical Center in Washington has yet to receive a dime for structural repairs to its main hospital and nursing home.

In order for VA to properly operate, maintain and improve its facilities, the Independent Budget recommends a minimum of $800 million for major and minor construction projects for FY 2003. It is important to keep in mind that the administration's request is $400 million for FY 2003.

For major construction, we recommend that Congress appropriate $400 million, $217 million higher than FY 2002. A majority of this funding request, $250 million, is needed for seismic corrections. Earlier in our testimony we noted our pleasure that VA is requesting major construction funds for seismic corrections, and we are also happy to see funding requests for national cemetery expansion.

We have also recommended $400 million for VA's minor construction account. This represents an increase of $190 million. This increase will support construction projects for inpatient and outpatient care support, infrastructure and physical plant improvements, research infrastructure upgrades, and an historic preservation grant program to protect VA's most important historic buildings. In order for VA to more effectively carry out these projects we recommend raising the ceiling on minor construction projects from the current $4 million per project to $16 million per project. As we have testified in the past, the current limitation results in a piecemeal approach to design and completion of projects that adds unnecessary delays, facility disruptions, and promotes poor fiscal management practices.

Other construction items recommended for increased funding include grants for state extended care facilities and state veterans' cemeteries.

As stated previously, we believe the administration's request is inadequate as it pertains to VA's construction programs. Further, we believe we have presented compelling evidence such as patient safety, asset management, and continued access to support our proposed increase. Therefore, we look to Congress to correct this shortfall. The passage of H.R. 811 would be a good step in that direction and a valid attempt to forestall the continued deterioration of VA's infrastructure. Yet without continued increases in construction appropriations to sustain VA facilities during the CARES process, there will be a need for authorizing legislation such as H.R. 811 every year in addition to appropriations. We look to the leadership of this committee to ensure adequate funding for Major and Minor Construction so that VA may realize its potential without compromising veterans' services.

Mr. Chairman, this concludes my statement and I will be pleased to answer any questions you or members of the committee may have.

Chairman ROCKEFELLER. Thank you very much, Paul.

STATEMENT OF RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Mr. RICHARD JONES. Mr. Chairman, we thank you for your time today. On behalf of Commander Joseph W. Lipowski, AMVETS is honored to join these veterans service organizations in providing you our best estimate for fiscal year 2003 spending.

AMVETS' primary focus is on funding for the national cemeteries in the new year. Before beginning on the budget, I would like to commend the Chairman for your strong leadership on veterans issues and legislative achievements in the First Session of this Congress. AMVETS and the members of the Independent Budget are truly grateful to you.

Members of the Independent Budget would also like to acknowledge the commitment of the National Cemetery Administration's staff. Their work at the World Trade Center, the Pentagon and Pennsylvania were outstanding.

Since its establishment, the National Cemetery Administration has provided the highest standards of service to veterans and eligible family members. Their work oversees 120 national cemeteries, located in 39 states, the District of Columbia and Puerto Rico. With the recent openings of four new national cemeteries within the last 2 years in Chicago, Albany, Cleveland, and Dallas and fast-tracked operations at Fort Sill and Atlanta, the National Cemetery Admin-

istration now maintains more than 2.5 million gravesites on nearly 14,000 acres of cemetery land.

With adequate funding for design and construction, development of national cemeteries will continue to future facilities in Miami and Pittsburgh, Detroit, and Sacramento. Currently, NCA provides more than 83,000 burials yearly. That is an 8-percent increase in workload over last year.

To ensure that the burial needs of veterans and eligible family members are met, the Independent Budget veterans' service organizations believe that the budget must be increased. To meet this commitment and maintain NCA facilities as national shrines, the Independent Budget veterans' service organizations recommend $138 million for NCA in fiscal year 2003. That is an increase of $17 million, and it does not include the $5 million Office of Personnel Management bump that is in the administration's request.

This level of funding will provide the additional full-time employees and the equipment necessary to maintain services. For funding the State Cemetery Grants Program, the members of the Independent Budget recommend $32 million for the new fiscal year. That is an increase of $7 million. As you know, the State Cemetery Grants Program works in complement with the NCA to establish gravesites for veterans in areas where NCA cannot fully respond to the burial needs of veterans.

Enactment of the Veterans Program Enhancement Act of 1998 has increased the activity and the attractiveness of this program. Through the State Grants Program, the National Cemetery Administration can now provide up to 100 percent of the planning, design and construction of approved new cemeteries in the states, and at the start of this current year, there were 10 new cemeteries under design, 11 in planning, and there were scheduled fast-track openings in central Indiana, northern Wisconsin, Arkansas, Massachusetts, Maine, and Montana.

The Independent Budget veterans organizations also request Congress to please review a series of burial benefits that have seriously eroded in value over the years. These benefits were never intended to cover the full costs of burial, but now, they pay for only a fraction of what they covered when they were first initiated in 1973. These burial benefits are included in the Independent Budget and outlined there specifically. We fully appreciate action in the first session to increase burial benefits, however we also would appreciate your giving these burial benefits a second look in the second session.

In addition, we would ask your committee to take a very careful look at the National Cemetery Administration's plans for the future. We face a dramatic upward increase in the interment rate, and members of the Independent Budget recommend the National Cemetery Administration work with you to help establish a strategic plan for the future. We must plan for a truly national system. It must have congressional and administrative budget support, and in this regard, we call on Congress to make funds available.

Mr. Chairman, this concludes my statement. I thank you again for the privilege to be here today.

[The prepared statement of Mr. Richard Jones follows:]

PREPARED STATEMENT OF RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Mr. Chairman, Ranking Member Specter, and members of the Committee:

AMVETS is honored to join fellow veterans service organizations in providing you our best estimates on the resources necessary to carry out a responsible budget for the fiscal year 2003 programs of the Department of Veterans Affairs.

AMVETS—a leader since 1944 in preserving the freedoms secured by America's Armed Forces—provides, not only support for veterans and the active military in procuring their earned entitlements, but also community services that enhance the quality of life for this nation's citizens.

AMVETS testifies before you today as a co-author of The Independent Budget. For over 16 years AMVETS has worked with the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars to produce a working document that sets out our spending recommendations on veterans' programs for the new fiscal year. Besides working with our coauthors on the overall development and publication of The Independent Budget, AMVETS' primary focus is on developing the recommendations for funding the National Cemetery Administration in the new year.

Before I address budget recommendations for the National Cemetery Administration, I would like to say that AMVETS fully appreciates the strong leadership and continuing support demonstrated by the Senate Veterans Affairs Committee. AMVETS is truly grateful to the members who serve on this important committee. Clearly, your achievements in the first session of this Congress demonstrate you have at heart the best interests of veterans and their families. You have distinguished yourselves as willing to work in a bipartisan manner to address numerous issues of great importance to the Nation's veterans.

Since its establishment, the National Cemetery Administration (NCA) has provided the highest standards of service to veterans and eligible family members in the system's 120 national cemeteries in 39 states, the District of Columbia, and Puerto Rico. A year ago, NCA opened cemeteries in Chicago, IL; Albany, NY; Cleveland, OH; and Dallas, TX. Late last year, fast-track operations were started at Ft. Sill, OK, and Atlanta, GA. And development will continue, with adequate funding for design and construction, for future facilities in Miami, Pittsburgh, Detroit, and Sacramento.

While the National Cemetery Administration maintains more than 2.5 million gravesites on nearly 14,000 acres of cemetery land, there remains a need to establish additional national cemeteries in some critically needed areas. AMVETS supports the Committee's active review of this matter and its continued encouragement of the Administration to meet the growing demand for space. Clearly, without the strong commitment of Congress and its authorizing and appropriations committees, VA would likely fall short of burial space for millions of veterans and their eligible dependents.

The members of The Independent Budget recommend that Congress provide $138 million and 1,525 full time employees for the operational requirements of NCA in fiscal year 2003. This is an increase of $17 million and 65 FTE over the 2002 current estimate level.

Currently, the NCA provides more than 83,000 interments annually, an eight percent jump over last year. The aging veteran population has created great demands on NCA operations and actuarial projections do not suggest a decline in these demands for many years. To ensure that the burial needs of veterans and eligible family members are met, the IBVSOs believe the budget must be increased to provide new staff and equipment improvements. Maintaining quality service with an accelerating workload will require additional resources. $138 million for the NCA will provide the additional full-time employees and necessary supplies and equipment for grounds maintenance and program operations.

For funding the State Cemetery Grants Program, the members of The Independent Budget recommend $32 million for the new fiscal year. The State Cemetery Grants Program works in complement with the NCA to establish gravesites for veterans in those areas where NCA cannot fully respond to the burial needs of veterans. The enactment of the Veterans Programs Enhancement Act of 1998 has made this program very active and attractive to the states. At the start of the current year, there were 10 new cemeteries under design and 11 new cemeteries in planning. There are also scheduled fast-track openings in central Indiana, northern Wisconsin, Arkansas, Massachusetts, Maine, and Montana. Through the State Grants Program, NCA can provide up to 100 percent of the planning, design, and construction of an approved new cemetery.

To properly support veterans who desire burial in state facilities, members of The Independent Budget support increasing the plot allowance to $670 from the current level of $300. The plot allowance now covers only 6 percent of funeral costs. Increasing the burial benefit to $670 would make the amount proportionally equal to the benefit paid in 1973. In addition, we firmly believe the plot allowance should be extended to all veterans who are eligible for burial in a national cemetery not solely those who served in wartime.

The IBVSOs also request Congress review a series of burial benefits that have seriously eroded in value over the years. While these benefits were never intended to cover the full costs of burial, they now pay for only a fraction of what they covered in 1973, when they were initiated.

The IBVSOs recommend an increase in the service-connected benefits from $2,000 to $3,700. Prior to action in the last session of Congress, increasing the amount $500, the benefit had been untouched since 1988. The request would restore the allowance to its original proportion of burial expense.

The IBVSOs recommend increasing the nonservice-connected benefit from $300 to $1,135, bringing it back up to its original 22 percent coverage of funeral costs. This benefit was last adjusted in 1978, and today covers just 6 percent of burial expenses.

The IBVSOs recommend changing current law to provide a headstone to mark the grave of all honorably discharged veterans upon request of the family. The current code, allowing a headstone only for unmarked graves, causes unnecessary confusion and unsettling aggravation to the families who see VA headstones at nearby marked sites and cannot understand why their loved one cannot likewise be distinguished. Providing a headstone is a small price to pay for commemorating the service of a veteran to our Nation.

The IBVSOs also recommend that Congress enact legislation to index these burial benefits for inflation to avoid their future erosion.

Finally, the IBVSOs note that the National Cemetery Administration's greatest challenge is yet ahead. Based on statistics projecting a dramatic increase in the interment rate until 2010, members of The Independent Budget recommend that the National Cemetery Administration establish a strategic plan for the period 2003 to 2008. We must plan for a truly national system, and it must have congressional and administrative budgetary support. We call on Congress to make funds available for planning and fast-track construction of needed national cemeteries.

Mr. Chairman, this concludes my statement. I thank you again for the privilege to present our views, and I would be pleased to answer any questions you might have.

Chairman ROCKEFELLER. Thank you, sir, for an excellent statement.

Mr. Fischl?

STATEMENT OF JAMES FISCHL, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. FISCHL. Mr. Chairman, thank you for the opportunity to appear before you today to express the views of the American Legion concerning the President's VA budget for fiscal year 2003.

Mr. Chairman, the American Legion is very appreciative of the work that you have done to advance the cause of our nation's veterans. We look forward to working with you again this year. We all remember where we were on 9/11. The American Legion national commander, Richard J. Santos, was preparing for testimony in this very room—not in this room; in the Cannon Building—but he was preparing testimony before a joint session of the Veterans' Affairs Committee. This presentation was not to be, however. The American Legion was being suddenly and brutally attacked, and before his testimony, the decision was made to evacuate the Capitol.

Although the national commander did not testify, he did submit his written testimony to both committees. In that testimony, the American Legion outlined its fiscal year 2003 budget recommenda-

tions for VA. The American Legion greatly appreciates the actions of all Members of Congress regarding the $1.3 billion increase in VA medical care funding for fiscal year 2002.

However, even with that substantial increase, it is not enough. It required a supplemental, and this becomes a very important issue, because the 2002 budget is the foundation for the 2003 budget. Because of the dramatic rise in the Priority 7 veterans in the use of VA health care and to keep enrollment open to Priority 7 veterans, Secretary Principi asked for a supplemental of the $142 million in the fiscal year 2002 appropriations. We applaud this effort to allow Priority 7 veterans to continue to enroll.

The American Legion believes, however, that this additional request will not cover the anticipated shortfall. The American Legion recommends increasing the proposed supplemental to $300 million, reflecting our original fiscal year 2002 funding level for VA medical care.

Focusing ahead to fiscal year 2003, the American Legion takes exception to the proposed budget being portrayed as an 8.3 percent increase, and I think the Secretary addressed this issue somewhat this morning in his testimony. And also, the Secretary spoke of the additional money that is not really an increase in the budget, and you pointed out, Mr. Chairman, that we can do better. The budget request is, in fact, a decrease and not really an increase.

While we understand that today's fiscal realities require VHA to seek other revenue streams to support the growing demand for service, the American Legion strongly recommends Medicare subvention as a more appropriate remedy. Medicare subvention will result in more accessible, quality health care for all Medicare-eligible veterans. Medicare is an entitlement that veterans have earned. The advocate community is strongly united on this issue. Medicare subvention must and will work.

The American Legion appreciates the support of this committee and looks forward to working with you to make this a reality. We also commend the Secretary for his commitment to Medicare subvention.

As for medical construction and infrastructure support, we believe that the CARES program has hampered this substantially, and there are many buildings that require seismic correction. We have identified over 70 buildings that need these corrections or modifications, and we feel that no veterans should be placed in harm's way while being hospitalized. They were placed in harm's way while in combat. They should not be placed in harm's way while in a VA hospital.

I would like to briefly talk a little bit about benefits. The fiscal year 2003 budget proposal outlines the various internal changes that the VBA is making and intends to make to improve the level of quality of service it provides. We do have some concerns about this. We are concerned about the work measurement, and we are concerned about accountability. And the task force mentioned accountability many, many times. We are concerned that they speak of the VA being accountable, but yet, on the other hand, they speak of transferring work to offices that are more capable of doing it. Our question would be if you have an office that is not functioning the way that it should, why are we not doing something about

that? Why are they not accountable? So that is a concern that we have.

We are also concerned about implementing the intent of VCAA. This legislation was intended to bring veterans into the light, to tell them what was required to successfully prosecute their claims. We are now very concerned that claimants are receiving only boilerplate notices of why their claim is being disallowed, and we are very, very concerned about this.

A claimant should know exactly what is happening with their claim and should know what it would take to perfect their claim, and we feel that they are just receiving boilerplate notices on that.

We also share the concern of the Independent Budget people that VA perhaps needs additional personnel. The Secretary has said if he needs more, he will ask for more. We feel that might be too late. You need to have them trained and ready to go at the time that you need them, so we are concerned about that.

We are also concerned in the decrease in the Board of Veterans Appeals staff. Their work is increasing, and we feel that they would need more rather than less people.

Mr. Chairman, that concludes my testimony. I would be happy to answer any questions that you might have.

[The prepared statement of Mr. Fischl follows:]

PREPARED STATEMENT OF JAMES FISCHL, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Thank you for the opportunity to appear before you today to express the views of The American Legion concerning the President's budget request for FY 2003 for VA.

On September 11, 2001, The American Legion National Commander, Richard J. Santos, was preparing to present testimony before a joint session of the Veterans' Affairs Committees, when America was attacked by terrorists. Although the National Commander did not testify, he submitted his written testimony to both Committees. In that testimony, The American Legion outlined its FY 2003 budget recommendations for VA. Copies of this congressional testimony were shared with the Administration.

The American Legion continues to believe that the primary mission of the Veterans Health Administration is to meet the health care needs of America's veterans. The American Legion greatly appreciates the actions of all Members of Congress regarding the $1.3 billion increase in VA medical care funding for FY 2002.

Congress, like The American Legion, quickly recognized that the President's budget request for FY 2002 was totally inadequate. Immediately after the President signed the FY 2002 budget, Secretary Principi was prepared to end the enrollment of additional Priority Group 7 veterans. Many of these veterans would have included recently separated service personnel from the Persian Gulf War, Kosovo and even Afghanistan. Fortunately, President Bush intervened and agreed to seek supplemental appropriations to allow VHA to continue its enrollment of additional Priority Group 7 veterans. Recently, VA briefed The American Legion that the Administration will seek a $142 million supplement to the FY 2002 appropriations. The American Legion still believes this additional request will not cover the anticipated shortfall.

The American Legion recommends increasing the proposed supplemental to $300 million reflecting The American Legion's original FY 2002 funding level for VA medical care.

VETERANS HEALTH ADMINISTRATION (VHA)

The American Legion finds it hard to contemplate the President's FY 2003 budget request without a clear vision of FY 2002 funding. Focusing ahead, The American Legion is very concerned with VA's approach to the veterans' medical care budget in FY 2003.

The major reason for Secretary Principi's inadequate FY 2002 estimates was the dramatic increase of new patients choosing to enroll in VA. Many factors are driving more veterans to use VHA as their primary health care provider:

- Many Medicare+Choice health maintenance organizations (HMOs) withdrew from the program;
- Many HMOs have collapsed;
- VHA has opened community based outpatient clinics;
- Double-digit increase in health care premiums;
- The dramatic fluctuations in the national economy make VHA a more cost-effective option for veterans; and
- VHA's reputation for quality of care and patient safety is attracting new patients.

Where comparable data exists, VHA continues to outperform the private sector in all indicators in health promotion and disease prevention. The American Legion adamantly believes VHA is the best health care investment of tax dollars. The average cost per patient treated within VHA is unmatched by any other major health care delivery system, especially with comparable quality of care.

The reason VHA medical care continues to increase annually is not due to uncontrollable cost increases or poor cost estimates, but rather because thousands of veterans are voting with their feet. More and more veterans are choosing to use their earned benefit—access to VHA. However, enrollment in VHA is clearly limited by existing discretionary appropriations. The American Legion urges Congress to evaluate several options that would assure every veteran that wants to enroll in VHA can enjoy that earned benefit. The key factor driving the increases in medical care funding requirements is the unexpected and dramatic increase in demand for care from VHA.

The American Legion does not oppose veterans paying for the treatment of non-service-connected medical conditions. In fact, The American Legion's GI Bill of Health (a blueprint for VA health care for the 21st Century) advocates collecting from veterans and all third-party insurers, including Federal health insurers. This plan also recommends VA provide health care benefits packages on a premium basis for those veterans with no health care coverage.

To cover the cost of the dramatic increase in the enrolled Priority Group 7 veterans population, VA proposes a $1500 deductible for the Priority Group 7 veterans. The American Legion questions the President's logic behind this new initiative to collect $363 million. The VA shows an "accounting adjustment" of $892 million, (cost of the Civil Service Retirement System and Federal Employees Health Benefit Program accrual for employees) as an increase in the medical care funding. Add to that the first-party and third-party collections from the Medical Care Collection Fund (MCCF), which VA estimates will reach nearly $1.5 billion. This budget picture presented to veterans is seriously skewed. After stripping away all of these "increases" the actual request for increase in medical care funding is $1.4 billion, barely covering the cost of inflation. In essence, veterans will be paying the cost of the "increase" out of their pocket.

Under the President's plan, VA would charge Priority Group 7 veterans 45 percent of reasonable charges until the deductible amount of $1500 is reached. After the deductible is met, the inpatient and outpatient co-payments will resume. According to VA, approximately 25 percent of Priority Group 7 veterans report having billable insurance. According to VA, 55–60 percent of Priority Group 7 veterans are over the age of 65, and thus Medicare-eligible. VA is prohibited from billing the Centers for Medicare and Medicaid Services (CMS), but can bill the Medicare supplemental insurers. Only the remaining 15–20 percent of Priority Group 7 will be expected to generate over $500 million in medical care costs.

In FY 2002, VHA estimates first-party collections will reach $228 million. VHA estimates that in FY 2003 it will collect $192 million in first-party collections. In FY 2002, VHA estimates third-party collections will reach $577 million. VHA predicts FY 2003 will generate $529 million in third-party reimbursements. VHA expects to collect $363 million in deductibles in FY 2003. This new proposal calls for fewer first-party reimbursements, fewer third-party reimbursements, but more in deductibles.

The American Legion believes these are optimistic estimates, at best. VHA's past MCCF performance in meeting collection expectations is a major concern to The American Legion. VHA's billing and collection reputation is rather embarrassing.

The American Legion believes in order for billing and collections to improve VA must be provided with the resources to obtain the necessary technology and to properly train MCCF personnel or consider contracting out the entire process.

Unlike in the private sector, Medicare-eligible veterans cannot use their Medicare benefits in a VHA facility. When Medicare-eligible veterans receive health care

treatment for any medical condition in the private sector, the federal government reimburses the health care provider for a portion of that service. When Medicare-eligible veterans receive health care treatment for the same medical conditions within VHA, the federal government will not reimburse VHA for any portion of that service. This equates to a restriction on veterans' right to access health care of their choice and using their Medicare insurance coverage.

The American Legion believes that Medicare subvention will result in more accessible, quality health care for all Medicare-eligible veterans. Furthermore, Medicare subvention should greatly reduce incidents of fraud, waste and abuse in billing because it will occur between two Federal agencies with congressional oversight. Today's fiscal realities requires VHA to seek other revenue streams to supplement the growing demand for service and not simply rely on saving more dollars to serve more veterans. The American Legion strongly recommends allowing Medicare subvention for Medicare-eligible veterans enrolled in VHA.

While there is much dialogue concerning the tremendous patient population growth, very little has been mentioned about the addition of health care professionals to meet the growing demand for health care. The American Legion understands that there are currently many veterans waiting to enroll in VHA. Additional health care professionals will also help reduce the long waiting periods for appointments, especially for specialized care. In the private health care industry, there is great concern over the growing nursing shortage, yet this budget fails to address any recruitment or retention proposal, much less, funding.

The American Legion recommends VHA medical care receive $23.1 billion in FY 2003 and that all third-party reimbursement, to include Medicare, be considered as a supplement rather than an offset.

MEDICAL AND PROSTHETIC RESEARCH

The contributions of VA medical research include many landmark advances, such as the successful treatment of tuberculosis, the first successful liver and kidney transplants, the concept that led to the development of the CT scan, drugs for treatment of mental illness, and development of the cardiac pacemaker. The VA biomedical researchers of today continue this tradition of accomplishment. Among the latest notable advances are identification of genes linked to Alzheimer's disease and schizophrenia, new treatment targets and strategies for substance abuse and chronic pain, and potential genetic therapy for heart disease. Many more important potentially groundbreaking research initiatives are underway in spinal cord injury, aging, brain tumor treatment, diabetes and insulin research, and heart disease. The American Legion views these research advances as so significant that it has devoted a column in its magazine to VA Research and Development.

Dollar for dollar, others recognize VA as conducting an extraordinarily productive research program. Currently the VA devotes 75 percent of its research funding to direct clinical investigations and 25 percent to bioscience.

The Quality Enhancement Research Initiative (QUERI) is the highest priority within the VA's Research and Development program. The Institute of Medicine has recognized this program as the best of its kind. QUERI is a multidisciplinary, data-driven national quality improvement program designed to promote the systematic translation of evidence into practice. In other words, "putting research results to work." Currently, QUERI focuses on 10 priority conditions. These conditions include congestive heart failure, heart disease, mental health, substance abuse, HIV/AIDS, diabetes, stroke, spinal cord injury, dementia/Alzheimer's and prostate cancer. Without sufficient funding, VA will not be able to continue all of the QUERI initiatives that involve new technology and the cutting edge of scientific advances. This will have a direct impact on the rapidly aging veteran population.

VA's overall research program requires a significant increase in funding above current levels in each of the next several years to perform important research and evaluation studies. The President's budget request of $409 million is inadequate and should be increased, especially with the growing threats of nuclear, biological and chemical terrorism.

The American Legion recommends $420 million for the research budget in FY 2003.

MEDICAL CONSTRUCTION AND INFRASTRUCTURE SUPPORT

Major Construction

The VA major construction program continues to be under funded. The major construction appropriation over the past few years has allowed for only one or two projects per year. For FY 2001, 16 major ambulatory care or seismic correction

projects were submitted to OMB. Of this number, only one major VHA project was recommended. For FY 2002, 28 major projects have been submitted for funding.

Over the past several years, The American Legion has testified that VA's major and minor construction appropriation must include all infrastructure priorities. Unfortunately, over the past several years, VA has not received appropriate funding

Private consultants have been warning for years that dozens of VA patient buildings were at the highest level of risk for earthquake damage or collapse. Currently, the VHA has identified 890 buildings in its inventory as being at risk. Of those 890, 560 are identified as essential—defined as bed, clinic, psychiatric, research, boiler plant, etc. Additionally, VHA has identified 67 patient care and other related use buildings as Extremely High Risk—danger of collapse or heavy damage. Along with the necessary ambulatory care and patient safety projects, it will require well over $250 million to address VHA's current major construction requirements.

The Capital Asset Realignment for Enhanced Services (CARES) program has impeded construction projects throughout VHA. Many much needed construction projects that would maintain and update VHA's infrastructure are being put on the back burner while CARES awaits full implementation. The American Legion fears that the CARES process does not allow for the local VA managers to implement the facility improvement projects that they know are necessary to maintain a functional service delivery system. The President's budget request for only $194 million severely inhibits VHA's ability to properly care for America's veterans.

The American Legion recommends $310 million for major construction in FY 2003.

Minor Construction

The American Legion believes that Congress must be consistent from year to year in the amount invested in VHA's infrastructure. Annually, VHA must meet the infrastructure requirements of a system with approximately 5,000 buildings that support 600,000 admissions and over 35 million outpatient visits. This accomplishment requires a substantial inventory investment. The FY 2001 appropriation of $166 million for minor construction was not nearly enough to meet future physical improvement needs. With the added cost of the CARES program recommendations and the nearly $42 million request for minor upgrades in the research facilities, it is essential that funding be increased considerably from that of past fiscal years. It would be foolish to reduce this investment. The President's budget request for $211 million falls short of VHA's minor construction needs.

The American Legion recommends $219 million for minor construction in FY 2003.

GRANTS FOR THE CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

The State Extended Care Facilities Grant Program continues to be a cost-effective provider of quality care services to the nations' veterans who require domiciliary, nursing home, and hospital care. The State Veterans Home Program must continue, and even expand its role as an integral vital asset to VA. State homes are in a unique position to help meet the long-term care requirements of the Veterans' Millennium Health Care and Benefits Act (Public Law 106–117). By 2010, 42 percent of the entire veteran population, an estimated 8.5 million veterans, will be 65 or older, with half of that number over 5 years of age. By 2030, most Vietnam Era veterans will be 80 years of age or older.

As many VA facilities reduce long-term care beds and VA has no plans to construct new nursing homes, state veterans' homes are relied upon to absorb a greater share of the needs of an aging population. If VA intends to provide care and treatment to greater numbers of aging veterans, it is essential to develop a proactive and aggressive long-term care plan.

The Veterans Millennium Health Care and Benefits Act requires VA to provide long-term nursing care to veterans rated 70 percent disabled or greater. The new law also requires VA to provide long-term nursing care to all other veterans for service-connected disabilities and to those willing to make a co-payment to offset the cost of care. Further, it requires VHA to provide veterans greater access to alternative community-based long-term care programs. These long-term care provisions have placed greater demand on VHA and on the State Extended Care Facilities Grant Program. This legislation has been on the books for almost 2 years and it is time for full implementation.

The American Legion believes it makes economic sense for VA to look to State governments to help fully implement the provisions of PL 106–117. VA spends on average $225 per day to care for each of their nursing care patients and pays private-sector contract facilities an average per diem of $149 per contract veteran. The national average daily cost of care for a State Veterans Home nursing care resident

is about $140. VA reimburses State Veterans Homes a per diem of $40 per nursing care resident. Over the long term, VA saves millions of dollars through the State Extended Care Facilities Grant Program.

The American Legion supports the State Extended Care Facilities Grant Program and believes the federal government must provide sufficient construction funding to allow for the expected increase in long-term care veteran patients. The President's budget request for $100 million should be increased to help meet the growing demand for care by veterans of the "Greatest Generation."

The American Legion recommends $110 million for the Grants for the State Extended Care Facilities for FY 2003.

NATIONAL CEMETERY ADMINISTRATION (NCA)

The National Cemetery Administration (NCA) is making great strides in meeting the interment needs of the nation's veterans and their dependents. As of October 31, 2001, NCA maintains more than 2.4 million gravesites at 120 national cemeteries in 39 states (and Puerto Rico). Currently, 75 percent of all veterans live within 75 miles of open national or state veterans' cemeteries. The ultimate goal is to have 90 percent of all veterans living within 75 miles of open national or state veterans' cemeteries.

NCA's workload is increasing by nearly five percent per year, with cremations accounting for the majority of new interments. The peak years for the interment of World War II veterans is expected to be 2006 to 2010. Over the next decade, new national cemeteries are planned for Atlanta, GA; Miami, Fl; Pittsburgh, PA; Detroit, MI; and Sacramento, CA. P.L. 106–117 requires NCA to contract a study to determine where additional national and state veterans' cemeteries will be required through 2020.

NCA is preparing "fast track" construction projects to open new national cemeteries. This allows burials to occur in each section of a new cemetery as it is being constructed. Instead of taking the conventional approach to new cemetery construction, "fast track" authority would permit the planned new national cemeteries to open in less than half the normal time, which is seven years. The most recent cemetery to open under the "fast track" authority is the Fort Sill, Oklahoma National Cemetery. Burials began on November 5, 2001.

The National Shrine Initiative continues to be one of the highest priorities of the NCA. This is an ongoing commitment and scheduling continues to fulfill the pledge of aesthetically improving the national cemeteries. Major improvements and renovations have started at several cemeteries with wonderful results. However, there is much that remains to be done. A tremendous amount of time and money is needed to continue this commitment.

The American Legion recommends $140 million for NCA in FY 2003.

STATE CEMETERY GRANTS PROGRAM

The State Cemetery Grants Program, which provides 100 percent federal funding for new state veterans' cemeteries, has received a significant increase in the number of state cemetery applications. Within the next several years, NCA is hopeful that up to 30 new state veterans' cemeteries will be opened. The workload and budgetary requirements of NCA will continue to grow over the next 15–20 years. The American Legion continues to fully support the further development of the State Cemetery Grants Program.

The American Legion recommends $30 million for the State Cemetery Grants Program in FY 2003.

VETERANS' EMPLOYMENT AND TRAINING PROGRAMS (VETS)

The American Legion adamantly opposes the President's new initiative to transfer VETS from the Department of Labor (DoL) to VA.

In the President's budget request for FY 2003, he proposes to add $197 million to VA budget for a new competitive grant program that replaces programs currently administered by DoL. The American Legion expressed opposition to a similar recommendation proposed by the Congressional Commission on Servicemembers and Veterans Transition Assistance back in 1999. The American Legion strongly suggests this Committee consider oversight hearings before such an initiative is allowed to prevail. DoL has all of the expertise and resources for effective job placement and training. The National Veterans Training Institute (NVTI) provides standardized training for all veterans' employment advocates in an array of employment and training functions.

Some suggest that moving VETS to VA would improve the overall performance of VA's Vocational Rehabilitation Program (Voc Rehab). Others would argue that

moving Voc Rehab to VETS in DoL would be a much better approach. Nearly all VETS employees attend NVTI and receive continuing training, few (if any) Voc Rehab employees have attended NVTI training. The American Legion perceives the relationship between VETS and DoL much more germane than VETS and VA.

The American Legion welcomes the opportunity to work with the Assistant Secretary for Veterans' Employment and Training (ASVET) and his staff to improve and enhance the overall performance of VETS. However, The American Legion believes reinventing the wheel within VA would be counterproductive and ineffective. The American Legion believes that many of VETS problems stem from persistent inadequate Federal funding, failure to be staffed at Federally mandated levels, and inconsistent national leadership.

The mission of VETS is to promote the economic security of America's veterans. This stated mission is executed by assisting veterans in finding meaningful employment.

Annually, DoD discharges approximately 250,000 service members. These recently separated service personnel are actively seeking immediate employment or preparing to continue their formal or vocational education. The veterans' advocates in VETS program play a significant role in helping the recently separated service personnel (veterans) reach their employment goals.

1) VETS continues to improve by expanding its outreach efforts with creative initiatives designed to improve employment and training services for veterans.

2) VETS provides employers with a labor pool of quality applicants with marketable and transferable job skills.

3) VETS took the initiative in identifying military occupations that require licenses, certificates or other credentials at the local, state, or national levels.

4) VETS helps to eliminate barriers to recently separated service personnel and assist in the transition from military service to the civilian labor market.

VETS started an information technology project with the Computing Technologies Industry Association, to recruit veterans recently separated from the military; assess their interest and skill level for a career in information technology; provide occupational skills training and certification; and place these veterans into information technology jobs. VETS continues to expand its PROVET (Providing Re-employment Opportunities for Veterans) program. PROVET is an employer-focused job development and placement program that focuses on screening, matching and placing job ready transitioning service members into career-building jobs. PROVET programs are currently operating in several states. In addition to employment services, VETS also supports the Transition Assistance Program (TAP), the Disabled Transition Assistance Program (DTAP), Veterans Preference in the Federal workplace, and the Uniformed Services Employment and Re-employment Rights Act (USERRA).

The American Legion strongly recommends restoring funding for the ASVET within DoL's FY 2003 budget at a funding level of $300 million. Staffing levels for Disabled Veterans Employment Program Specialists and Local Veterans Employment Representatives should match the Federal mandates or those statutes should be rewritten. The American Legion recommends an increase in the NVTI budget to $3 million annually. The American Legion further recommends that VA send Voc Rehab employees to NVTI training.

VETERANS BENEFITS ADMINISTRATION

Under the proposed budget for FY 2003, mandatory spending for compensation, pension, education, burial, and other benefit programs is expected to be $31.5 billion. This is an increase of $3.4 billion over the level approved for FY 2002. It represents the funding requirements for ongoing statutory benefit payments to some 3.25 million veterans, dependents, and survivors, as well as the impact of recent, expanded statutory and regulatory entitlements, higher average benefit payments, and certain new legislative proposals. It also includes an estimated 1.8 percent cost-of-living adjustment.

Under General Operating Expenses (GOE), the budget request for FY 2003 includes a total of $1.2 billion for discretionary spending to cover staffing and other costs associated with the administration of the various benefits and service programs within the Veterans Benefits Administration (VBA). This represents a net increase of $94 million over the amount approved for FY 2002. It includes an additional 125 FTE to support current efforts to bring the case backlog under control and support a new case development program at the Board of Veterans Appeals. The budget request also includes funding for a number of information technology initiatives that will provide much needed direct and indirect support toward improving the claims process.

In addition to this modest staffing increase, the FY 2003 budget request for VBA describes a number of steps that, over time, are expected to steadily reduce the backlog of pending cases to about 250,000 and the claims processing time to 100 days by the end of FY 2003. As part of the strategy to reach these rather ambitious goals, VBA has implemented a broad spectrum of regulatory, programmatic, and administrative changes, in addition to its long-term strategic plan initiatives, that are intended to improve the regional offices' operational efficiency and decision-making. Also, recommendations of the Secretary's Claims Processing Task Force have been accepted and are in the process of being implemented over the next year. VA expects these changes to produce both near-term and long-term improvements in the quality and timeliness of the decision-making process.

The data upon which VBA's budget request is predicated shows a continued overall increase, rather than a decrease, in the volume of incoming claims. With more complex claims per case and the level of available adjudication expertise, it is doubtful that regional offices will be able to achieve the dramatic increases in production and improvements in quality that will be necessary to reach the claims processing goal of 100 days with a backlog of 250,000 cases. In an effort to achieve such ambitious production goals, The American Legion is concerned that regional offices will emphasize expediency rather than ensuring full compliance with the due process and assistance requirements of the Veterans Claims Assistance Act and other provisions of the law. Even with the implementation of the many changes and efficiencies described, claims development and adjudication will continue to be a very labor intensive and time-consuming process.

The American Legion believes that the requested staffing increase is insufficient to meet the expected workload demand in FY 2003.

BENEFIT PROGRAMS

The American Legion is pleased to see some special attention being given to expediting the 81,000 oldest claims by the nation's oldest veterans. No veteran or survivor should have to wait a year or longer for a decision on their claim, least of all elderly claimants. Tragically, many die before receiving a decision and the long-awaited benefits to which they were entitled. The Tiger Team initiative at the Cleveland VA Regional Office and the nine Service Delivery Network (SDN) Resource Centers will go a long way toward alleviating much of the hardship and frustration that thousands of veterans experience while waiting for their claim to be decided.

The FY 2003 budget proposal outlines the various internal changes VBA is making and intends to make in order to improve the level and quality of the service it provides veterans. However, there are a number of external factors that have an ongoing impact on VBA's ability to drastically improve regional office performance and production. In FY 2003, while there will be a slight decrease in the number of pension claims, this will be more than offset by the substantial increase in the overall number of compensation claims. Most of this increase is expected to come from the continued influx of new and reopened claims. The number of Agent Orange-related diabetes claims is expected to be up substantially over FY 2002. VBA must also rework thousands of cases as a result of Nehmer v. United States Veterans' Administration.

Congress has recently expanded entitlement to service connection for radiation-related diseases as well as disabilities affecting veterans who served in the Persian Gulf War. The requirements of the Veterans Claims Assistance Act of 2000 have greatly increased the regional office's workload and processing time. The United States Court of Appeals for Veterans Claims and the United States Court of Appeals for the Federal Circuit have continued to issue precedent decisions requiring frequent and often far-reaching changes in adjudication procedures and the reworking of thousands of previously decided and pending cases.

The American Legion tentatively supports VBA's proposed initiatives for FY 2003. We hope these will enable substantial progress to be made toward the overall goal of providing veterans proper and timely decisions on their benefit claims.

The American Legion is deeply concerned that the 125 additional staff for VBA in FY 2003 may not be adequate, if VBA is to be even partially successful in meeting its stated claims processing goal of 100 days.

BOARD OF VETERANS APPEALS

Veterans or other claimants must have the right to appeal any decision by the regional office to the Board of Veterans Appeals (BVA or the Board). BVA staffing for FY 2002 is 464 FTE. In FY 2003, however, it is projected to further decline to 451 FTE. The American Legion is again concerned by this reduction. Given the cur-

rent number of initial appeals and remands pending in the regional offices coupled with the fact that the Board will soon begin a major new initiative to do the development work that the regional offices would have normally done pursuant to a BVA remand, manpower shortages may adversely impact on the timeliness of decisions.

In FY 2001 and for the first quarter of FY 2002, the number of new appeals filed in the regional offices has continued to rise. This reflects a high level of dissatisfaction with regional office actions. However, over the same period of time, the number of cases transferred to the Board has steadily declined, due to the overall slow down in claims processing. In particular, regional office compliance with the requirements of the Veterans Claims Assistance Act has prolonged the development of appeals and their eventual transfer to the Board.

The American Legion's longstanding concern with the appeals process is with those factors that contribute to an annual influx of 60,000 to 70,000 new appeals. Veterans and other claimants feel they are not treated fairly or properly by a system that is very complex, highly bureaucratic, and legalistic. They feel very strongly that the process is basically adversarial and not "user friendly." This perception is reinforced by the fact that, in FY 2001, the BVA allowed the claimant's appeal in 22.3 percent of the cases and remanded 48.8 percent of the appeals for further required action. The Board only affirmed regional office decisions 27 percent of the time.

Of the approximately 60,000 appeals decided in FY 2000 and 2001, the Board remanded about 32,000 cases for additional development and readjudication. Unfortunately, most of the appellants in these cases are still waiting on action by the regional offices. Some of these appeals date from 1997 and 1998, and as noted previously, the issue on appeal in these cases is much older still.

Remands involve substantial additional work for the regional offices. To try and reduce this portion of their workload as well as provide more timely decisions on all appeals, VA regulations will go into effect later this month authorizing the BVA to fully develop appeals without the necessity of remanding them back to the regional office of such action. This will involve reorganization of the BVA staff and the reassignment of a limited number of FTE from the Compensation and Pension Service to assist in the additional development work.

Under this new program, it's expected that the Board will be able to provide more expeditious and complete development of appeals. In FY 2001, with a staff of 454 FTE, the BVA issued approximately 31,000 decisions. Of these decisions, approximately 8,500 or 48.8 percent were remands. Now, the Board itself will undertake this development in the majority of those cases, which would have otherwise been remanded. The American Legion believes that more, rather than fewer staff at the Board will be needed in FY 2003 to handle this additional workload.

By substantially reducing the number of remands, the regional offices should be able to concentrate on completing more pending benefit claims and completing the outstanding remands. While The American Legion believes this new procedure will ultimately benefit veterans and provide more timely service, we are concerned that, in the interest of expediency, the regional offices may try and use this program as a way around full compliance with their responsibilities under the Veterans Claims Assistance Act. In our view, the high remand rate of the past several years is a direct reflection of poor decision-making and the lack of an effective quality assurance program. Since the BVA will be assuming the responsibility for correcting errors and mistakes by the regional offices, there will be an incentive for the regional offices to try and shift as much of the appellate workload onto the Board as possible. VBA must ensure this does not happen. More stringent quality assurance standards and performance measures must be promptly implemented. To make this program a success there must also be a closer working relationship and improved communication between VBA and the Board at all levels.

The American Legion recommends a total of $1.3 billion in VBA–GOE.

HOMELAND SECURITY

The important role of VA in Homeland Security is not highlighted in the President's budget request. The American Legion saw the critical actions of VA in response to the September 11, 2001 disasters. VA employees sprang into action to assist response personnel, victims, and surviving family members. Yet, VA was not actually a part of any emergency response plans immediately implemented, but rather acted unilaterally. VA employees provided medical care, counseling, and claims processing. VA was prepared to do even more if called into action.

The Director of Homeland Security, Tom Ridge, will need the cooperation of an array of Federal agencies. Since VA medical facilities are geographically diverse, VHA is a logical partner for the pre-positioning of inoculations and medical supplies

needed to address acts of terrorist or natural disasters. Currently, every VA campus is scheduled to undergo an evaluation under CARES. Homeland Security requirements must be included in the criteria used to determine possible utilization of physical plants that may currently be considered underutilized.

In the event of a nuclear, chemical, or biological terrorist attack, each VA campus may become a key element in the care and treatment of mass causalities. As national emergency plans are reviewed at every level of government—local, state, and national—VA must be seen as valuable resource. Whether housing response workers, military forces, or law enforcement personnel; providing quality medical care; or serving as a command, control and communications center, VA must have the resources to meet the assigned mission as back up to DoD and the National Disaster Medical System.

SUMMARY

Mr. Chairman and Members of this Committee, The American Legion applauds the leadership of President Bush and his Administration, especially under the current wartime conditions. As an organization of wartime veterans, we continue to stand shoulder-to-shoulder with the President, Congress, and our comrades-in-arms—past, present, and future.

The American Legion knows that the President's budget request is focused on winning the war on terrorism. Therefore, adequate defense spending is extremely critical and The American Legion fully supports the direction the President has chosen. However, the cost of waging war continues long after the dead are buried, the guns are silenced, and the treaties are signed. The war continues to rage in the hearts and minds of its veterans. No combat veteran completely walks away from any war untouched, physically or mentally.

The cost of freedom rests in this nation's ability to recruit and retain young men and women willing to pay the ultimate sacrifice in the name of liberty. This nation has been blessed since its inception with similar citizen-soldiers, sailors, airmen, and Marines that have set a standard of excellence for others to follow. Recently, a new generation of Purple Heart recipients demonstrated on the field of battle the courage, determination, and loyalty exhibited by—the Minutemen, the Roughriders, the doughboys, the GIs—that preceded them in protecting and defending America against all enemies, foreign or domestic.

Mr. Chairman and Members of this Committee, The American Legion doesn't ask for much, just another installment in the ongoing cost of freedom.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO JAMES R. FISCHL

DISCOURAGING PRIORITY 7 VETERANS THROUGH $1500 DEDUCTIBLE

Question 1. Please comment on the VA's proposed $1,500 deductible for Priority 7 veterans. In my memory, this is the first time we have a proposal on the table that aims to drive away existing VA health care users. What are your thoughts about this proposal?

Answer. Many would argue that this is not the first time a proposal was offered to drive away existing VA health care users. With the enactment of PL 99–272, Congress established means testing within VHA that placed veterans into three categories: A, B, and C. Category C veterans had very little access to VHA. Wisely, Congress enacted PL 104–262 that allows VHA to enroll all veterans within existing appropriations. Now the challenge is to generate enough revenue through Federal appropriations, co-payments, deductibles, and third-party reimbursements to meet the growing demands for quality health care.

The American Legion opposes the $1500 deductible, as proposed in the President's budget request. The American Legion does not oppose certain veterans paying for the treatment of non-service-connected medical conditions. We have consistently offered alternative ideas on how veterans could pay for the care of their non-service-connected medical conditions. The American Legion's GI Bill of Health (a blueprint for VA health care for the 21st Century) advocates collecting from veterans and all third-party insurers, to include all Federal health insurers, such as Medicare. The GI Bill of Health also recommends VA provide health care benefits packages on a premium basis for those veterans with no health care coverage.

The American Legion continues to advocate for Medicare subvention for VHA for the treatment of non-service-connected medical conditions of enrolled Medicare-eligible veterans in Priority Group 7. There are logical reasons to justify Medicare subvention:

• The majority of enrolled Medicare-eligible veterans meet or exceed the 40 quarters standard of Medicare covered employment.
• For Priority Group 7 veterans, Medicare is a pre-paid Federal health insurance plan.
• All enrolled Medicare-eligible veterans are free to choose any health care provider. Based on the quality of service provided in VHA and its pharmacy, many Medicare-eligible veterans wisely opt for VHA.
• As a Federal health care provider, VHA's billing should not exceed Medicare's allowable rates.
• Under current law, VHA is authorized to bill and collect third-party reimbursements, with few exceptions. Medicare is normally the secondary payer and would meet these criteria.
• VHA is an integrated health care delivery system, which could easily accommodate the Medicare+Choice option of the Centers for Medicare and Medicaid Services (CMS).
• Direct billing between two Federal agencies, VA and CMS, should greatly reduce opportunities for fraud, waste, and abuse.
• Priority Group 7 veterans' access is contingent upon the ability to collect both copayments and third-party reimbursements.
• Medicare-eligibility does not grant a person access to VHA health care.
• VHA's quality of care compares favorably when benchmarked against Medicare providers' performance measures of quality.

ELIMINATING VA'S CLAIMS BACKLOG

Question 2. Clearly, VA's current claims backlog is intolerable, and new steps are needed to improve the claims process. We know from past experience that VA's attempts to streamline this process often lead to a temporary slowdown that makes the problem worse. What steps do you think that VA could take, and what resources would be necessary, to prevent the backlog from swelling even more while VA puts its new plans into place?

Answer. The American Legion has a number of concerns with VA's recent efforts to address the backlog of pending claims, in regard to staffing, and quality assurance issues. Secretary Principi's often-repeated promises to improve VA's service have significantly raised veterans' level of expectation. However, it remains to be seen if VA can, in fact, deliver quality decisions in a timely manner.

Under ideal circumstances, a backlog of almost 600,000 pending cases might not be too large, if these could be processed in a reasonable amount of time with a high degree of user satisfaction and few appeals. However, when Secretary Principi took over VA in 2001, VBA was in the process of hiring large numbers of new adjudicators and integrating them into a very labor intensive, claims adjudication system. He also inherited a backlog that was growing in size, age, and complexity.

At this time last year, the backlog of pending cases was some 485,000 with about 91,000 over six months old. In the eight weeks since the first of this year, the number of compensation and pension cases in process has risen from 548,846 to 594,030 or a net increase of about 5,800 cases per week. The core staff of experienced adjudicators must try and balance the continuing need to train the new hires with the need for production.

It is apparent, based on VBA's weekly work reports, that despite current efforts, including the additional staff, VBA has not been able to stem the growth in the overall backlog of claims and appeals, although there has been a slight decline from 230,000 to 229,000 cases over six months old. This may be a sign of some initial progress in reducing at least one part of the backlog. More time is needed to see if this favorable trend continues.

In recent months, there have also been a variety of new initiatives to process the oldest pending cases, such as the use of the Tiger Team and SDN Resource Centers. Regional offices are putting most of their time and effort into claims processing, rather than expediting appeals, which are claims that often go back two, three, or more years. There are currently about 96,400 pending appeals, including some 32,000 remands. The recent change in VA regulations permitting the BVA to do development work on appeals rather than remanding them is a partial solution to the regional offices continuing poor quality decision-making problem. A coordinated VBA/BVA quality assurance program may help improve regional office performance, in the long run.

VA continues to emphasize that they are now doing more claims actions as more and more of the new adjudicators complete their basic training. We believe this gives a false impression that VA has turned the corner and the backlog is on its way to being controlled. More claims actions, however, does not necessarily mean

that more claims are being completed and benefits paid. We are concerned about compliance with the VCAA.

Claimants are entitled to an explanation of the decision process and what would be required to grant the benefit sought. In visiting regional offices we have observed that claimants are being provided with boilerplate explanations rather than meaningful responses. We are also concerned that the emphasis on requesting submission of evidence in thirty days will result in premature denials followed by reopened claims when the evidence is later submitted. Workload reports will then reflect improved timelines and productivity. The current work measurement system does not provide accurate, reliable data on the time it actually takes to complete a claim. It has a long history of manipulation and abuse and does not provide management necessary and appropriate information on regional office staffing and resource needs.

We believe the backlog will get worse before it gets better. If VA is going to be even partially successful, it must avoid the types of problems it created for itself and veterans in the handling of the backlog crisis of the mid-1990s. At that time, all efforts were focused on production in order to reduce the backlog and claims processing time. VBA's training program was essentially put on hold. Quality in decision-making was subordinated to expediency. There was no effective quality assurance program. Overall "customer dissatisfaction" was reflected in a sustained high rate of appeals filed.

BVA overturned the regional office's actions two-thirds of the time. The poor quality work and unnecessary appeals squandered valuable federal resources and taxpayers' dollars. It also subjected many veterans and their families to prolonged financial and emotional hardship while their claims and appeals churned through an uncaring system. The lessons of the recent past are: VBA must have a strong training program, even though it constrains station output somewhat in the short-term; VBA must have an independent, effective quality assurance program that tracks individual and station performance; and there must be sufficient staffing in order for VBA to carry out its claim processing responsibilities.

Looking at its announced goals, current tasks, and future challenges, including the need for succession hiring, we do not believe the proposed increase of 125 FTE for VBA in FY 2003 will be adequate. Unfortunately, we are unable to suggest an appropriate staffing level, since the details of VBA's FY 2003 GOE request have not yet been released to the public.

SHORTFALLS IN THE MEDICAL CARE BUDGET

Question 3. The level of funding proposed for this year includes a mishmash of shifting funds, revenue collections and new charges to veterans. It's hard to tell what the actual new appropriated medical care funding amount is but it is safe to say that it is no where near the $3.14 billion increase proposed by the Independent Budget. What initiatives and funding needs will the Independent Budget cover that are not going to be met by the Administration's budget?

Answer. The American Legion is not affiliated with the Independent Budget; therefore, The American Legion will not comment on the Independent Budget or its recommendations. However, we applaud their dedication and commitment to America's veterans.

Annually, The American Legion presents its budget recommendations before a joint session of the Veterans' Affairs Committees shortly after The American Legion's National Convention. During this early Fall hearing, The American Legion offers its recommendation for the next fiscal year. This provides the Committees, other Members of Congress, and the Administration The American Legion's expectations well before the President's budget request is submitted to Congress.

On September 11, The American Legion submitted to the Veterans' Affairs Committees, its recommended funding level for VA in FY 2003. The American Legion recommends VHA medical care receives at least a $23.1 billion funding level in FY 2003. This is a $1.8 billion dollar increase over last year's medical care budget. Moreover, The American Legion has always believed that all third-party reimbursements, to include Medicare, be considered as supplements rather than offsets.

Obviously, that recommendation does not include the transfer of funding from the Office of Personnel Management (OPM) to pay for the Federal employee benefits (Civil Service Retirement System and Federal Employees Health Benefit Program) addressed in the President's budget request for FY 2003. The American Legion does not oppose this bookkeeping adjustment; however, this adjustment would increase The American Legion's request, as well. Congress should not confuse this OPM transfer as an increase in funding for the delivery of health care. In fact, The American Legion believes the FY 2002 VA medical care budget still needs a $300 million

in supplement appropriations to avoid the rationing of health care delivery in local VA medical facilities at the end of the fiscal year.

VHA has seen a dramatic rise in the Priority Group 7 veterans' population use of VHA facilities and services, most notably pharmacy services. The American Legion believes that all veterans should maintain their eligibility status and none of the Priority Group 7 veterans should ever be disenrolled because of budget constraints. The American Legion is deeply concerned with the Medical Care Collection Fund (MCCF). Eligibility reform was based on the premise that Priority Group 7 veterans would generate revenue through co-payment and third-party reimbursements to offset the additional costs. The majority of the Priority Group 7 enrollees are either Medicare-eligible or do not have third-party insurance coverage.

The American Legion recommends:

- Authorizing VHA to bill, collect and retain reimbursements from Medicare;
- Authorizing VHA to offer premium-based health care policies (basic care, complex care, or specialized services) for Priority Group 7 enrollees with no third-party coverage; and
- Requiring VHA to either dramatically improve internal MCCF collections or contract out MCCF collections.

Another observation concerning the tremendous grow in VHA enrollment is the significant lack of additional health care professionals hired to meet the patient demand for services. Two years ago, PL 106–117, the Veterans' Millennium Health Care and Benefits Act of 1999, provided greater specificity in directing VA to address long-term care. The American Legion is deeply concerned that VA is not aggressively meeting that congressional mandate.

TRANSFER OF THE VETERANS EMPLOYMENT AND TRAINING SERVICE (VETS)

Question 4. VA is proposing a new competitive grant program that would shift VETS from the Department of Labor to VA. Do you think that VA is better equipped to provide employment and training services to veterans? What effects will the transfer have on veterans?

Answer. The American Legion adamantly opposes the President's new initiative to transfer VETS from the Department of Labor (DoL) to VA.

DoL possesses all of the expertise and resources for effective job placement and training. The National Veterans Training Institute (NVTI) provides standardized training for all veterans' employment advocates in an array of employment and training functions.

Some suggest that moving VETS to VA would improve the overall performance of VA's Vocational Rehabilitation Program (Voc Rehab). Others would argue that moving Voc Rehab to VETS in DoL would be a much better approach. Nearly all VETS employees attend NVTI and receive continuing training, few (if any) Voc Rehab employees have attended NVTI training. The American Legion perceives the relationship between VETS and DoL much more germane than VETS and VA.

The American Legion welcomes the opportunity to work with the Assistant Secretary for Veterans' Employment and Training (ASVET) and his staff to improve and enhance the overall performance of VETS. However, The American Legion believes reinventing the wheel within VA would be counterproductive and ineffective. The American Legion believes that many of VETS problems stem from persistent inadequate Federal funding, failure to be staffed at Federally mandated levels, and inconsistent national leadership.

The mission of VETS is to promote the economic security of America's veterans. This stated mission is executed by assisting veterans in finding meaningful employment.

Annually, DoD discharges approximately 250,000 service members. These recently separated service personnel are actively seeking immediate employment or preparing to continue their formal or vocational education. The veterans' advocates in VETS program play a significant role in helping the recently separated service personnel (veterans) reach their employment goals:

- VETS continues to improve by expanding its outreach efforts with creative initiatives designed to improve employment and training services for veterans.
- VETS provides employers with a labor pool of quality applicants with marketable and transferable job skills.
- VETS took the initiative in identifying military occupations that require licenses, certificates or other credentials at the local, state, or national levels.
- VETS helps to eliminate barriers to recently separated service personnel and assist in the transition from military service to the civilian labor market.

VETS started an information technology project with the Computing Technologies Industry Association, to recruit veterans recently separated from the military; as-

sess their interest and skill level for a career in information technology; provide occupational skills training and certification; and place these veterans into information technology jobs. VETS continues to expand its PROVET (Providing Re-employment Opportunities for Veterans) program. PROVET is an employer-focused job development and placement program that focuses on screening, matching and placing job ready transitioning service members into career-building jobs. PROVET programs are currently operating in several states. In addition to employment services, VETS also supports the Transition Assistance Program (TAP), the Disabled Transition Assistance Program (DTAP), Veterans Preference in the Federal workplace, and the Uniformed Services Employment and Re-employment Rights Act (USERRA).

SAVING MONEY THROUGH SHARING UNUSED VA SPACE

Question 5. Three years ago GAO criticized VA for having over 5% of its space unoccupied. GAO said that VA was losing a million dollars a day. I think that we would all agree that many more veterans could be served if the VA had an additional $360 million dollars. What can VA do to create more sharing opportunities? With what organizations might they share?

Answer. Clearly best practices need to be shared by those that have a successful sharing agreement, joint venture or cooperation.

Currently, VA and DoD sharing occurs among 165 Veterans Affairs Medical Centers (VAMC) and most military medical treatment facilities. VA and the military have agreed to share 7,963 services covering a broad range of hospital related activities. Both Departments are exploring ways to improve coordination of service delivery in such areas as long-term care, pharmacy, chiropractic services, and radiology.

The American Legion is impressed with the joint venture sites it has visited and other sharing arrangements it has reviewed. There is a clear indication of benefits for both systems. The American Legion encourages VA and DoD to continue to explore more avenues for cooperation and to assist other areas of the country in formulating and negotiating these opportunities. The American Legion believes there are many more of these opportunities out there to be developed. The number and types of sharing agreements (as indicated by the amount of dollars exchanged) are minor, relative to the overall budgets for each Federal agency.

In reviewing the cooperative efforts between VA and DoD, The American Legion identified several different ways in which VA and DoD could cooperate:

- buy or sell services between the Federal agencies. VHA facilities are authorized to make maximum effective use of their resources and can provide services to community entities when there is no diminution of services to veterans. All revenue generated from the sale of services is used to enhance care for eligible veterans. During 2000, there were 1,136 new contracts for resources purchased ($289,712,000) and provided ($32,090,000) totaling $321,802,000. This is a significant increase in activity from past years in resources purchased. The expanded authority gives VHA the mechanism to make the best use of available resources to purchase services in the most cost-effective manner.
- share staff, such as having reservists drill at VA hospitals, especially since VA is affiliated with many medical schools.
- share technology and other equipment. A mammography machine, which might not be a justifiable cost for one, can become beneficial if bought jointly as was done in Albuquerque.
- conduct joint education and training. VA is affiliated with 103 medical schools.
- co-purchase pharmaceuticals and medical/surgical supplies. They can share supplies and borrow pharmaceuticals from each other in emergency situations.
- VA can increase its role as a TRICARE sub-contractor.
- patient medical records and other information can be jointly accessed to enable service members a smoother transition from active duty.

The American Legion's approach to underutilized space is to utilize the space. Veterans are waiting to enroll in VHA—a great many of them are Priority Group 7 veterans—those veterans capable of generating new revenue through co-pays, deductibles, and third-party reimbursements. VHA has a long-term care congressional mandate that is currently not being aggressively met. Some of this current underutilized space may be a cost-effective approach towards meeting its long-term care objectives. Other veterans, already enrolled, experience long waiting periods for appointments. If they have other alternatives, such as Medicare or third-party coverage, they may very well go elsewhere with their health care dollars.

The American Legion continues to caution Congress and VA to evaluate these physical plants from a proactive rather than a reactive mindset. Once the property is gone, replacement may be twice the cost of renovation, restoration, or replacement. These decisions should not be purely budget-driven, but rather patient-driven.

The question should be asked, "What services could this facility provide to VHA beneficiaries?"

The American Legion would rather see these spaces used by contract health care provider, contracted long-term care providers, or National Guard medical battalions rather than being eliminated from VA's inventory. Based on increased concerns for Homeland Security and the War on Terrorism, VHA role as a back up to DoD during national emergencies or natural disasters must also be factored into future evaluation of capital assets.

DECEPTIVE INCREASE IN BENEFITS BUDGET

Question 6. Although this year's budget recommends a $94 million increase in funding for VBA, more than half of that will be consumed in an administrative shift of employees' benefits. Even given the efficiencies that VBA hopes to gain in processing claims, what do you think the short- and long-term impact of this budget will be for veterans?

Answer. VBA discretionary funding in FY 2003 indicated an increase of $94 million. This gives the general impression that additional funding is being requested for more staffing in the regional offices and, thereby, improving claims processing and service to veterans. However, in reality, the net increase in GOE is $40 million and 125 FTE. The difference of $54 million reflects a bookkeeping adjustment for employee retirement benefit costs. We believe this an attempt to mislead veterans and the Congress into thinking that VBA has turned the corner on the backlog problem and only a modest increase in staff is needed.

VBA has hired several thousand new employees in the last two years and embarked on a variety of major programmatic changes that are intended to improve the quality and timeliness of its services. We believe VBA is still in a transitional phase and the full impact of these initiatives has yet to be seen. The staff build-up of the last several years has been essential in order to offset previous years of severe staffing cutbacks and develop a new cadre of adjudicators to handle the existing workload and eventually replace retiring senior adjudicators. We strongly believe this build-up must continue, at least through FY 2003. However, a more specific recommendation about staffing needs will be contingent upon an analysis of the data in VBA's GOE FY 2003 budget request, which is not yet available. Training is a long-term investment and must remain a central part of VBA's strategy to provide veterans the benefits and services they expect and to which they are entitled.

FUNDING FOR MEDICAL RESEARCH

Question 7. This year's Medical and Prosthetics Research Budget request is actually 6% higher than last year's request. The VA says that this will allow for 76 new projects and an additional 184 staff. What are your thoughts on this level of funding for research?

Answer. The American Legion continues to recommend an increase in Medical and Prosthetics Research. The American Legion's budget recommendation for FY 2003 is $420 million. With the growing threats of nuclear, biological and chemical terrorism, and the direct impact medical and prosthetic research has on the rapidly aging veterans' population, we believe the level of funding for research outlined in the President's budget is too low. Recent advances, such as identification of genes linked to Alzheimer's disease and schizophrenia, new treatment targets and strategies for substance abuse and chronic pain, are very important to the veterans' population. Additionally, VA is conducting very progressive research in spinal cord injury, aging, brain tumor treatment, diabetes and insulin research, and heart disease. The American Legion views these research advances as so significant that it has devoted a column in The American Legion Magazine to VA Research and Development.

MEDICARE SUBVENTION

Question 8. I notice that you support Medicare subvention for the VA. Several years ago the Department of Defense had this opportunity and ended up spending more than they collected. Why do you feel that the VA would be successful at this when DoD wasn't?

Answer. Currently, Indian Health Service is successfully billing and collecting from the Centers for Medicare and Medicaid Service (CMS) for both Medicare and Medicaid. TRICARE for Life is DoD's newest version of Medicare subvention and is being heralded by DoD as successful. The American Legion is unaware of any third-party reimbursement billing and collection problems being experienced with CMS by either of these Federal agencies. Therefore, The American Legion believes similar success could be experienced by VHA with CMS' assistance.

One noticeable barrier is the concept known as level of effort or maintenance of effort. In DoD's first attempt with Medicare subvention, this philosophy became a reality in the budgeting formula. In essence, DoD was tasked to continue to treat an estimated number of Medicare-eligible patients, before DoD could bill CMS for any new Medicare-eligible patients. This faulty assumption was somewhat confusing, because the entire patient population being treated by DoD was eligible for care based solely on honorable military service. Medicare-eligibility had absolutely nothing to do with access to care, but rather a coincidence. Medicare-eligibility in and of itself did not justify care within DoD. Initially, Medicare-eligibility disqualified a patient from participation in TRICARE. Level of effort or maintenance of effort should not apply to VHA, as well.

Another problem with DoD's demonstration program was the negotiated reimbursement rate once DoD surpassed its level of effort or maintenance of effort. DoD agreed to bill CMS at 90 percent of the reimbursement rate. Private health care providers are screaming that the full reimbursement rate is too low, yet DoD would receive even less. The contractual agreement between CMS (HCFA) and DoD doomed this demonstration project from the very beginning.

Medicare is a Federally mandatory, pre-paid senior health benefit insurance policy. Currently, Medicare-eligible beneficiaries are free to use their Medicare throughout the private sector and in other Federal health care delivery systems, except VHA. Enrollment in other health care insurance policies is normally voluntary, yet veterans' enrolled in VHA are required, by law, to identify any third-party health benefit coverage to be billed for the treatment of service-connected and non-service-connected medical conditions. The American Legion believes VA and CMS could achieve Medicare subvention on two levels: fee-for-service or Medicare+Choice. However, in either case, VA must be treated like an integrated, quality health care delivery system by CMS. In return, CMS should not be billed for the treatment of any non-service-connected medical conditions or the treatment of economically indigent veterans. Under current law, VA is congressionally mandated to deliver quality health care for service-connected medical conditions and economically indigent veterans.

Chairman ROCKEFELLER. Thank you, and thank you all very, very much.

It happens occasionally that I miscalculate, and today is one of those days. I overestimated the amount of time that I would be able to be here. I also have 10 questions for you, and I have concluded that I cannot ask them at this time.. And so, what I am going to do is the next best thing, which is actually sometimes even better. I am going to submit the questions to you, and they will cover some of the areas that you have discussed and some that you have not discussed and would ask if you would be kind enough to get back to me within about 2 weeks. There is no law on that; but as you can get them done, it would be very helpful.

[The information referred to follows:]

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER TO THE CO-AUTHORS OF THE INDEPENDENT BUDGET*

DISCOURAGING PRIORITY 7 VETERANS THROUGH $1,500 DEDUCTIBLE

Question 1. Please comment on the VA's proposed $1,500 deductible for Priority 7 veterans. In my memory, this is the first time we have a proposal on the table that aims to drive away existing VA health care users. What are your thoughts about this proposal?

Answer. The Independent Budget is opposed to the Administration's proposal to begin charging a $1500 deductible for health care for category 7 veterans. The primary reason we can see for the imposition of a deductible requirement is to discourage currently eligible veterans from seeking VA health care. Recently, the Administration announced that it would continue enrolling category 7 veterans. It said that it would find the resources to cover the costs of these health care services. Instead of providing the additional resources, it has proposed to have veterans pay for this

*AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars.

care out of their own pockets. The VA itself estimates that a deductible will deter 121,000 new veterans from seeking health care. Requiring a $1500 deductible could adversely affect lower-income veterans, veterans whose insurance will not pay the deductible, and who want and need to go to the VA particularly to provide services they cannot find elsewhere in the private sector or on Medicare, for instance long-term care, prescription drugs, or specialized services. Finally, we are concerned about the perverse disincentive that this deductible scheme could have on veterans who represent the core mission of the VA.

ELIMINATING THE CLAIMS BACKLOG

Question 2. Clearly, VA's current claims backlog is intolerable, and new steps are needed to improve the claims process. We know from past experience that VA's attempts to streamline this process often lead to a temporary slowdown that makes the problem worse. What steps do you think that VA could take, and what resources would be necessary, to prevent the backlog from swelling even more while VA puts its new plans into place.

Answer. The claims backlog in VA is intolerable. We would not characterize the solution as "new steps" to "improve the claims process," however. We believe the current claims process is fundamentally sound, although improvements can always be made with evolving technology and process innovations. We contend that decisive action is needed to improve claims processing. Experience has shown that past attempts to streamline the process has led to decreases in production. It is known that improvements come at a cost. Under what has been termed the "incorporation effect," the incorporation of new skills or methods for long-term improvement causes short-term decline in performance. However, we believe VA's past attempts to improve have not produced the desired results because they were half-heartedly implemented, did not take a well-managed and carefully-monitored strategic approach, or, in some instances, were misguided.

Perhaps several improvements could contribute to VA's overall efficiency in claims processing, but first and foremost, VA must tackle the root causes of the claims backlog. We have discussed the root causes and our recommendations in general terms in The Independent Budget for Fiscal Year 2003 at pages 26–27.

One factor contributing to the backlog was the improvident reduction in staffing in VA's C&P service in past years. VA has increased its workforce to address the claims backlog. Initially, new employees tend to add to the burden on the system rather than to increase production, because experienced employees must devote part of their time to training. As training progresses, new employees can begin to contribute some to case production. This requires more employees in the short term, but eventually the work could be done with fewer employees if it were not for the continual turnover in old and new employees. The intervention of other unforeseen factors into this complicated situation makes accurate projection of future staffing needs very difficult. However, without OMB constraints, VA can roughly determine how many employees it currently needs to allow it to train new employees, retrain existing employees, perform essential quality review, and maintain case production enough to minimize short-term declines in case production. In the fluid dynamics of the current situation, perhaps the only workable solution is to let staffing levels follow current demand, and hopefully a more forward-looking, strategic approach can be employed once the current crisis is brought under control and a level of stability is attained. Unfortunately, the political goals of the budget process in OMB seem to drive VA's request for resources more than its real needs. The President's FY 2003 budget suggests that increased staffing is not the answer quoting the Chairman of the VA Claims Processing Task Force: "I must say that I think the VA has the necessary resources right now to do the job . . . the Agency can't justify asking for more people right now." However, even the Administration does not appear to subscribe to that blanket statement because the President's budget requests authority for 96 additional FTE for compensation and pension claims processing. From our discussions with VA management outside the budget process, The Independent Budget recommends 350 additional FTE for C&P Service. We agree that any number of additional FTE will not solve the problem unless VA gets more serious about correcting the root causes of its problems.

SHORTFALLS IN THE MEDICAL CARE BUDGET

Question 3. The level of funding proposed for this year includes a mishmash of shifting funds, revenue collections and new charges to veterans. It's hard to tell what the actual new appropriated medical care funding amount is but it is safe to say that it is no where near the $3.14 billion increase proposed by the Independent

Budget. What initiatives and funding needs will the Independent Budget cover that are not going to be met by the Administration's budget?

Answer. The Administration has proposed a medical care appropriation of $22.744 billion, an increase of $1.4 billion over FY 2002. Although veterans appreciate any increase, we are also cognizant of the fact that this does not meet the needs of the VA in the coming fiscal year, and does not provide the resources necessary to ameliorate the effects of recent inadequate appropriations. Unless additional resources are provided, the current situation, as intolerable as it is, will continue into the foreseeable future, and sick and disabled veterans will once again be shortchanged by the very government they have served, and rely upon to care for them.

The FY 2002 budget falls short by at least $1.5 billion. Already, a few short months into FY 2002, the Administration has reported a shortfall of close to $500 million, and is seeking supplementary funding, a step we fully support nationally, we are witnessing an explosion in health care costs, especially in pharmaceutical costs which increased 17.3 percent in 2000. VA health care budgets have not kept pace with this explosive spending growth.

Again, we note that the Administration's budget relies upon "management efficiencies" to address real budgetary needs. Inadequate appropriations force the VA to ration care by lengthening waiting times and delaying services.

We have not included collections as part of our recommendations concerning appropriated dollars. We recognize that nonappropriated funding may be available to expand VHA operations and ultimately improve care for veterans. However, we are strongly committed to the principle that the cost of VA health care is a federal responsibility that must be met in full by Congress and the Administration through adequate appropriations. VA must not be forced to rely on subsidies from veterans or their insurers to cover the costs of caring for veterans.

We are very concerned that the Administration has failed to provide funding for the VA to meet its critical fourth mission—to serve as a backup to the Department of Defense in times of war or national emergency. The Administration's budget fails to address this issue with adequate funding.

TRANSFER OF THE VETERANS EMPLOYMENT AND TRAINING SERVICE (VETS)

Question 4. VA is proposing a new competitive grant program that would shift VETS from the Department of Labor (DOL) to VA. Do you think that VA is better equipped to provide employment and training services to veterans? What effects will the transfer have on veterans?

Answer. The authors of The Independent Budget for fiscal year 2003 do not directly address the transfer of the Veterans Employment and Training Service programs. However, we do make recommendations on the DVOP and LVER programs.

The members of The Independent Budget believe veterans would be best served by funding DVOP and LVER programs at the statutorily mandated levels. With adequate funding, we believe that enough staff would be available to provide maximum services to veterans. At minimum, we recommend sufficient funding to ensure the DVOP and LVER programs remain national in scope and that DVOP/LVER staff be assigned to each major office from which services are provided to veterans in transition to the job market.

In addition, the members of The Independent Budget recognize a clear need to institute consistent performance standards for the VETS programs. These standards should be in place to improve and strengthen available management tools and enhance overall program effectiveness. Without performance standards, the system has no way to compare one state to another, or even one office to another within a state. Recent testimony from the DOL Assistant Secretary for VETS indicates movement in the right direction with a strong focus on developing these management tools.

The partnership members of The Independent Budget have recommended several improvements in the DVOP/LVER programs to make these programs work better so more veterans can get the help they need to find better jobs. As outlined above, these include adequate funding and improved performance standards.

AMVETS Answer.* Shifting VETS to VA from DOL will not improve the employment and training needs of veterans. Within DOL, VETS has a wealth of departmental knowledge at its disposal. DOL knows the job market and the skills required to fill jobs over and above any other executive department.

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*Because the proposal to cut the VETS programs from the Department of Labor arose after our collaboration on The Independent Budget, AMVETS submits the attached response to Question 4 regarding the transfer of DOL/VETS to VA.

While we agree that DOL needs to review its structure and process for the delivery of employment services to veterans, AMVETS does not agree that radical amputation of VETS from DOL is a solution to improving job placement.

We do not see how VA is prepared to accept a program, which so naturally suits DOL. VA has its own challenges with backlogs in claims processing and lengthy waiting lists for health care. In forcing VETS upon the VA, we fear that the main mission of the VA will be further backlogged and jeopardized.

Certainly VA has the ability to provide outreach to veterans at their time of separation, but DOL knows the labor marketplace, and they know better than anyone else where the jobs are. To date, the only rationale given for the shift is that VA wants to become a "one stop shop" for veterans programs, but they have ignored veterans' programs in departments and agencies other than DOL. VETS must be retained within the DOL and the VA must be allowed to continue its valued service to our veterans.

In addition, AMVETS notes that the administration proposes no funds in fiscal year 2003 for the National Veterans' Training Institute. Because NVTI is the only source of formal training available to federal and state employees for veterans employment programs, the Institute is vital to the success of VETS. We believe that NVTI should be funded at a level adequate to ensure training is continued.

SAVING MONEY THROUGH SHARING UNUSED VA SPACE

Question 5. Three years ago GAO criticized VA for having over 5% of its space unoccupied. GAO said that VA was losing a million dollars a day. I think that we would all agree that many more veterans could be served if the VA had an additional $360 million dollars. What can VA do to create more sharing opportunities? With what organizations might they share?

Answer. As you may recall, that same GAO report stated, "restructuring . . . could reduce budget pressures or generate revenues that could be used to enhance veterans' health care benefits." The VA's Capital Asset Realignment for Enhanced Services (CARES) process serves the purpose of identifying all the facilities that will be retained, consolidated, or reconfigured. It is, therefore, our position that VA needs to incorporate sharing agreements into this process as much as possible.

One organization sticks out above all others when it comes to sharing and potential cost savings—the Department of Defense (DOD). It is important to note that although there are areas where VA and DOD can improve upon existing sharing agreements they are two, separate and distinct entities with different missions: One, to fight and win the nation's wars; and the other, to care for those who bear the scars from those wars. DOD conducts its health care mission as a direct care provider and insurance purchaser (TRICARE) for members of the Armed Forces, retirees, and their dependents through the Military Health System (MHS) while VA conducts its health care mission as a direct care provider to honorably discharged veterans through the Veterans Health Administration (VHA). As such, they both possess cultural and institutional barriers that must be broken down, or at the very least mitigated, in order to create a healthcare partnership. We know from experience that this is easier said than done.

There are areas, however, such as joint ventures that come to mind immediately. For example, the Alaska VA Healthcare system that boasts a VA/DOD hospital shared with the 3rd Medical Group, Elmendorf Air Force Base. Locating other areas around the country where military bases and VA facilities are in close proximity has the potential to produce similar results.

The Independent Budget cannot emphasize enough our conviction that any sharing agreement between DOD and VA conform to 38 U.S.C. §8111(c)(1) in that it not "adversely affect the range of services, the quality of care, or the established priorities for care provided by either agency." Simply put, we will support only that which does no harm to the beneficiary no matter the cost savings that may be generated. Further, any savings realized as result of a sharing agreement should be immediately reinvested into their respective health care systems without offset from congressional appropriation.

In addition to DOD, there is the potential to pursue sharing agreements with HHS and other governmental agencies charged with medical preparedness in case of war or national emergency.

Further, the private sector provides another avenue for sharing, especially when it comes to long-term care. Contracting enhanced use leases to provide such services as Residential Care, Respite Care, Hospital Based Home Care, Adult Day Health Care, and other extended care programs.

Aside from the private sector, VA should consider leasing space to non-profits, specifically homeless veterans advocates.

We also support VA's partnering with the National Trust for Historic Preservation within the context of the CARES process to ensure the appropriate, lawful, and financially prudent management of VA's historic properties.

VFW's Answer.* GAO found that DOD needed to manage patient care and cost more efficiently. Unlike DOD, VA's mission is to take care of veterans. It is our opinion that the Veterans Health Administration (VHA) is the most efficient and cost-effective health care system. Scientific research has proven that VHA provides care for 25 percent to 30 percent less than comparable Medicare services. VHA makes no profit, buys no advertising, pays no insurance premiums, and compensates its physicians and clinical staff significantly less than private-sector health care systems. VA manages to provide this more efficient and cost-effective care even though it serves a population of veterans that is older, sicker, and has a higher prevalence of mental and behavioral health problems.

Most important to us, as veterans' advocates, the report stated "enrollees in [the pilot program] said they were better able to get care when they needed it. They also reported better access to doctors in general as well as care at military treatment facilities. Enrollees generally were more satisfied with their care than before the demonstration."

The VFW has made Medicare subvention one of its top legislative priorities. This past August, our National Convention approved VFW National Resolution 4622 calling for a change in law that would authorize VA to collect and retain all Medicare dollars. I have attached a copy of this resolution for your information.

Again, we thank you for affording us the opportunity to present our views before your committee.

Resolution No. 622 VA MEDICARE SUBVENTION

WHEREAS, the VA health care system must provide all veterans access to a full continuum of care; and

WHEREAS, the Department of Veterans Affairs has suffered from years of chronic under-funding, limiting its ability to properly care for its current workload; and

WHEREAS, it is now absolutely essential that VA be authorized to capture and retain federal dollars in addition to its annual appropriation so as to revamp and revitalize its health care system; and

WHEREAS, a large number of VA's potential patients are Medicare eligible; now, therefore

BE IT RESOLVED, by the Veterans of Foreign Wars of the United States, that we support the swift enactment of legislation authorizing VA to collect and retain all Medicare dollars.

DECEPTIVE INCREASE IN BENEFITS BUDGET

Question 6. Although this year's budget recommends a $94 million increase in funding for VBA, more than half of that will be consumed in an administrative shift to employees' benefits. Even given the efficiencies that VBA hopes to gain in processing claims, what do you think the short- and long-term impact of this budget will be for veterans?

Answer. This President's budget is concerned more with making VA's numbers fit within the President's overall political agenda in the budget than addressing VA's true needs. Regrettably, VA's future direction and policy positions seem to be determined more by a few "bean counters" in OMB, who do not appreciate the purposes and philosophy of veterans' programs, than by VA management. OMB has become a dictatorship within a democracy, whose policies are moderated and countered only by a vigilant and determined Congress.

The Independent Budget recommendation for VBA under the General Operating Expenses appropriation is a "current services" budget with money added only for our recommendations of additional FTE and funding for specific information technology initiatives. Obviously, the President's budget requests funding for other ongoing and new initiatives that we have not requested funding for in The Independent Budget. Given that, the President's budget would appear to be inadequate. The Independent Budget recommendation includes funding for 350 additional FTE for C&P Service and two other information technology initiatives. Appropriations for other projects included in the President's budget should be added to The Independent Budget request. Otherwise, both the short- and long-term impact of this budget will only worsen an already unacceptable situation in claims processing. As

*Although VFW's responses are in accordance with those of the Independent Budget's, our view differs slightly to question No. 5.

with the President's budget overall, the request for VBA is inadequate. The $53.9 million included in the $94-million increase requested for VBA is somewhat deceptive but is unlikely to succeed in deceiving those who must give real consideration to its impact on veterans.

FUNDING FOR MEDICAL RESEARCH

Question 7. This year's Medical and Prosthetics Research Budget request is actually 6% higher than last year's request. The VA says that this will allow for 76 new projects and an additional 184 staff. What are your thoughts on this level of funding for research?

Answer. Although VA Medical and Prosthetic Research (MPR) has not suffered the same budget pressures that have beset health care, it is still suffering from the uncertainty it faces each budget cycle. The MPR account fell short by $24 million in FY 2002 and will result in numerous MPR projects to be placed on hold. With the modest increase requested by the Administration for FY 2003, the MPR account will be hard pressed to maintain the status quo.

VA MEDICARE SUBVENTION

Question 8. I notice that you support Medicare subvention for the VA. Several years ago the Department of Defense had this opportunity and ended up spending more than they collected. Why do you feel that the VA would be successful at this when DoD wasn't?

The Independent Budget Answer. The Independent Budget VSOs in general feel Medicare Subvention in some form may be appropriate. However, at this time there is no consensus with respect to the actual implementation or specifics of such. Each of the four Independent Budget VSOs will respond independently to this issue. Following are the responses from the Disabled American Veterans and the Paralyzed Veterans of America. AMVETS and the Veterans of Foreign Wars will respond by separate letter.

DAV Answer. We understand that DoD negotiated an unfavorable contract with Medicare that required it to exceed the level of effort and in addition it was a complex program including an HMO and Medicare Plus Choice delivery model which resulted in additional administrative problems.

We would encourage Congress to draft appropriate legislation to ensure problems faced by DoD would be rectified and that the contract between VA and Medicare would clearly outline the intended outcome for VA.

The DAV supports Medicare Subvention and we believe VA participation in this initiative will benefit veterans, taxpayers, and ultimately VA as long as Medicare subvention dollars are a supplement to an adequate VA appropriation. To offset federal appropriations for VA health care by revenue from Medicare makes no sense and benefits no one, not veterans, not the VA, not the Medicare Trust Fund, and not American taxpayers.

As you are aware, although access to health care is an earned benefit, based on honorable military service, it is not considered an entitlement; therefore, it is subject to annual discretionary appropriations. Priority level funding may change from year to year, depending on congressional appropriations. Currently, VHA is authorized to retain all copayments collected from Priority Group 7 veterans and third-party reimbursements collected from their private insurance companies. However, VHA is prohibited from billing Medicare for services rendered to Priority Group 7 Medicare-eligible veterans.

Medicare-eligible Priority Group 7 veterans have earned the right to use VA health care services. We strongly believe that Congress should pass legislation that permits Medicare-eligible Priority Group 7 veterans the option of choosing VA health care and using their Medicare coverage. Citizens purchase Medicare coverage through payroll deductions and should have the right to use those benefits to receive care from the provider of their choice. The VA health care system is well known for its specialized programs in areas such as blind rehabilitation, spinal cord injury, post-traumatic stress disorder, traumatic brain injury and mental health. Medicare subvention would give veterans who currently cannot use their Medicare coverage at VA facilities, but who need specialized care, the option of choosing the VA system and using their Medicare coverage. Additionally, VA believes it can deliver care to Medicare beneficiaries at a discounted rate, which would save money for the Medicare Trust Fund and stretch taxpayer dollars. Allowing Medicare-eligible Priority Group 7 veterans to apply their Medicare benefits in VA facilities would reduce the government's total health care expenditures. VA health care costs less, at least 25% less, than private-sector providers billing at Medicare rates. The savings could be realized by reduced cost to patients, through low or no copayments, or passed on

to taxpayers by setting subvention rates discounted from standard Centers for Medicare & Medicaid Services (CMS) rates, or by a combination. A large number of Priority Group 7 veterans bring diversity to the case mix and lower average costs. Finally, this group comprises a body of users that could be directed to other Medicare providers outside the VA system in case VA is needed to fulfill its fourth mission as backup to the Department of Defense in time of War or domestic emergency.

The VA Secretary determines Priority Group 7 veterans' access to VA health care on an annual basis. VA's ability to provide their care largely depends on if it receives an adequate appropriation for health care. From one year to the next, this group of veterans is not sure if they will be able to continue to use VA health care services. Secretary Principi was prepared to announce his decision to limit enrollment of new Priority Group 7 veterans for this year. At the last minute he reversed his decision based on a promise from the Administration to provide supplemental funding to VA to continue open enrollment for all priority groups in 2002. The potential closure of enrollment for new Priority Group 7 veterans demonstrates that appropriations cover only Priority Groups 1–6. Medicare Subvention would obviate the need to deny access to Priority Group 7 users.

The cost of care for this growing population of enrolled Priority Group 7 veterans exceeds medical care cost recovery (MCCR) from these patients and their secondary insurers. The DAV along with the Independent Budget (IB) group has consistently opposed the offset of MCCR collections. We believe that it is the responsibility of the Federal government to fund the cost of veterans' care; therefore, we do not include any cost projections for MCCR in the IB budget development. VA's historical inability to meets its collection goals has eroded our confidence in VA estimates. We have urged the Administration and Congress to drop this budget gimmick and address the veterans' medical care appropriations in a straightforward manner by providing a realistic budget fully funded by appropriations. We strongly believe monies collected through MCCR should be a supplement to, not a substitute for, appropriations. Collections from Medicare-eligible Priority Group 7 veterans do not cover the cost of their care, and since appropriations are not sufficient, these funds are redirected away from service-connected and poor veterans to subsidize the Medicare trust fund. Additionally, because of the shortfall in appropriated funds, services provided for the care of service-connected and poor veterans are delayed, and those veterans particularly must wait much too long to receive necessary care.

While we support Medicare subvention, we would want Congress to ensure that service-connected disabled veterans would not be displaced or forced to wait even longer for necessary care and that revenue generated from Medicare subvention will not be used to offset federal appropriations. It doesn't make any sense to replace appropriated funds with Medicare funds. There is no benefit to VA, Medicare, or taxpayers if VA appropriations are offset by Medicare revenues.

The assumption that subvention dollars should necessarily be offset by VA appropriation reductions is invalid because it is based on the incorrect belief that current appropriations are sufficient to provide services to service-connected, poor, and Priority Group 7 Medicare-eligible veterans. While VHA sets standards for quality and efficiency, veterans' access to health care is constrained. Consistently inadequate appropriations have forced VA to ration care by lengthening waiting times. Last year appropriations were barley sufficient to cover the cost of care for Priority Groups 1–6. Appropriations over the last several years have been insufficient to provide services to service-connected, poor, and Priority Group 7 Medicare eligible-veterans. By VA estimates, there are approximately one million Priority Group 7 users with 50–65 percent Medicare eligibility. Only 15 percent of Priority Group 7 Medicare-eligible users have billable Medigap insurance, leaving 85 percent where VA receives no insurance reimbursement. The average collections from Medigap insurance for Priority Group 7 Medicare-eligible veterans is estimated at only 12–13 percent of the possible total billable portion. Obviously, VA spends a significant amount of resources on providing health care services for Priority Group 7 Medicare-eligible veterans with little reimbursement. We strongly believe their health care costs should be covered by Medicare funds.

The director of CMS has stated that veterans' care should be covered by VA appropriations and that subvention would represent a double payment by the government. This is a spurious argument; actually, the current situation represents "reverse subvention" with VA appropriations used to pay for care that has already been funded by contributions to the Medicare Trust Fund. We estimate that $600 million of the veterans medical care appropriation is used to subsidize Medicare.

No veteran should be denied access to the veterans health care system. Veterans, even veterans like those in Priority Group 7, who are not poor, have the right to take advantage of VA health care. However, service-connected and poor veterans should not have to subsidize care for veterans who have public or private insurance

coverage. Medicare subvention would allow Medicare-eligible Priority Group 7 veterans to become a source of funding rather than a drain on an already over-extended system. We strongly urge the Committee to support Medicare subvention without offset to the annual appropriation.

PVA Answer. Medicare Subvention could benefit the provision of veterans health care, but, in PVA's view, only if the services provided equated to the full range of fee-for-service Medicare, and, if VA could be assured that appropriations to provide the full range of services for non-Medicare eligible would not be offset by collections from the Medicare Trust Fund.

REMAINING MANAGEMENT EFFICIENCIES IN VA HEALTH CARE

Question 9. In this year's Independent Budget, you state under Medical Care issues that "There are no more 'efficiencies' to be wrung out of the system." Are you saying that you believe that the VA can't be more efficient in their management of health care?

Answer. The Independent Budget will be the first to acknowledge there are always ways in which efficiencies can be improved. However, VA management efficiencies historically are achieved through the rationing or elimination of services and personnel. This can only result in longer waiting lines for sick and disabled veterans.

Chairman ROCKEFELLER. I very much appreciate the effort of veterans service organizations to try to work the budget process seriously, and I am on the Finance Committee. I receive many visitors who, shall we say, and always think about their particular niche. They never think about the larger situation. And what I think you all are trying to do—and I do not know of any representative that unite on behalf of an entire segment in our population. You look at the entire budget and try to present what you think is best and right for all veterans. And luckily you do not have the constraint of having to worry about the Office of Management and Budget.

Mr. Paul Wellstone has just entered, which means that he may ask all of my questions, Paul Wellstone, and because I am about to leave, you also become chairman.

Senator WELLSTONE. You know what, Jay, Mr. Chairman? I can do this in 30 seconds.

Chairman ROCKEFELLER. That, I have heard from you before. [Laughter.]

Senator WELLSTONE. No, no, watch it. Watch it. A, thank you everyone, and I had to chair a hearing on working poor, and I could not leave, because I was chairing it, and I apologize for missing this very important hearing. B, if the Secretary is still here, you know, I would thank him, and I would thank everybody, all of the panelists and people who are here for all of the work and getting compensation for atomic veterans and the homeless veterans bill, and thank you, Mr. Chairman, and then, see, I have just got to say that I see that there is an increase in the budget, but when I look at inflation, and I look at the commitments that we have made, I actually do not see that in relation to—I think we are short, and there are huge gaps, and I think we have got to do a lot better. And I think there is going to be a pretty significant debate on the Independent Veterans Budget, which is the direction I think we need to go in.

So thank you, everyone. I am ready to raise cain about the budget, and I will not say anything else.

Chairman ROCKEFELLER. That was not only substantive but accurate in terms of time.

And more importantly to me is that generally people come to our hearings and leave. But when people have been at other committee hearings and then come here, that is very duly noted by me. And that shows your commitment, and I appreciate that very much.

So with the previous apologies that I have made and thanks to all of you for your work and for your broader vision; thank you very much, and this hearing is adjourned.

[Whereupon, at 11:59 a.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL, U.S. SENATOR FROM COLORADO

Thank you Mr. Chairman. I would like to welcome you, Mr. Secretary, and thank you for appearing before the committee today. I am looking forward to your testimony which will give us a better picture of how the Administration is going to address the serious issues facing the VA at this time.

I am encouraged that President Bush wants to fulfill the nation's commitment to its veterans by guaranteeing that veterans' disability claims are processed accurately and quickly, and by focusing medical care resources on treating disabled and low-income veterans.

Though I am encouraged with the overall FY 2003 funding increase, and particularly the increase for health care, I continue to be concerned that we find a way to take care of what will be an increasing number of elderly veterans. In my home state of Colorado, several veterans clinics are no longer able to take new primary care patients due to a lack of funding and providers. I think we can all agree that one of our greatest national responsibilities is the welfare of our nation's veterans. It is critical that we find a balanced way to make good on the promises to them.

I also remain concerned about the backlog that continues to hinder the adjudication process of veterans' claims appeals. I understand that this is one of your priorities, and I heartily support you in that endeavor.

I will be listening carefully to the veterans who are meeting with me this month and I am looking forward to the testimony of the many service organizations that will be testifying at the joint hearings during the next few weeks.

Speaking as a veteran, I believe we need to do all we can to serve those who have so honorably served all of us.

Mr. Secretary, again, I thank you for being here. I look forward to hearing details of your budget proposal and how you plan to address these issues in an efficient and effective manner within the proposed budget.

I thank the chair and look forward to today's testimony.

PREPARED STATEMENT OF HON. LARRY E. CRAIG, U.S. SENATOR FROM IDAHO

Mr. Chairman. it is indeed a pleasure to welcome the VA Secretary Tony Principi and members of his staff. I applaud you and your team in your efforts to ensure our government honors our commitments to Veterans while implementing the most beneficial and cost effective programs. To do this, we must continually look for opportunities to reform the VA health care system, while maintaining as our number one priority, our combat veterans with disabilities or veterans with low incomes who often rely exclusively on the VA for their care.

The VA's Budget proposal totals $56.5 billion for Veterans' benefits and services, $30.1 billion for entitlement programs and includes $26.4 billion in discretionary spending, for medical care, burial services, and the administration of Veterans' benefits. This is an increase of almost $6 billion over last year's budget, and it clearly demonstrates the President's commitment to Veterans' Health Care.

I strongly support a VA which is committed to providing accessible, high quality medical care and other Veterans benefits and services in a timely and effective manner. However, we must expand and improve the delivery of service and benefits so that all Veterans have equal access to high quality medical care, particularly in under served rural areas such as Idaho. Of particular note are concerns that I have with the doctor shortage we are currently experiencing in our Pocatello facility. It is of utmost importance that the long list of Veterans waiting to receive various services, especially medical care, are able to get it in a timely, courteous manner with a minimal amount of necessary travel time. In recent years there were tremen-

dous staff reductions that resulted in reduced services. The necessary steps must be taken to reverse this trend.

In closing, Mr. Chairman, there is no way to over emphasize the honor and respect this nation owes the military men and women who sacrificed so much to accomplish a strong national defense. I believe that this proposed budget is a good beginning for ensuring our Veterans will receive high-quality health care, that we keep our commitment to maintain Veterans' cemeteries as national shrines, and we have the resources to process Veteran Benefit claims in a more timely and accurate manner. I look forward to working with Secretary Principi to meet the many challenges that the VA will face in the coming years.

PREPARED STATEMENT OF THE FRIENDS OF VA MEDICAL CARE AND HEALTH RESEARCH

The Friends of VA Medical Care and Health Research (FOVA), a coalition of 78 medical research, specialty, physician, academic, patient advocacy and industry organizations committed to quality care for veterans, is pleased to provide recommendations regarding FY 2003 funding for the Department of Veterans Affairs (VA) medical and prosthetics research program. FOVA strongly encourages the Committee on Veterans Affairs to support VA research by recommending an FY 2003 appropriation of at least $460 million and $45 million for research facility improvements.

FOVA's FY 2003 VA research recommendation builds on the $20 million increase provided for the current year. FOVA thanks the Committee for recognizing that the less-than-inflationary increase requested by the Bush Administration last year would have been detrimental to the long-term viability of the program. We are grateful for the Committee's strong leadership in securing a final outcome that was a significant improvement.

The Administration's FY 2003 budget request for a $23 million (6%) increase in research program dollars* is notable for being the first time in many years that an administration has proposed funding sufficient to maintain VA's current level of effort in advancing treatments for conditions particularly prevalent in the veteran population including prostate cancer, diabetes, heart diseases, Parkinson's disease, mental illnesses, spinal cord injury and aging related conditions. We applaud the Bush Administration and Department of Veterans Affairs Secretary Anthony J. Principi for recognizing the invaluable contribution VA research makes to delivering high quality care for veterans and toward improving the health of veterans and the nation.

However, a $23 million increase would not allow VA to expand its efforts to improve care for veterans, nor to meet the new challenges presented by the tragedies of September 11 and subsequent events. FOVA strongly encourages the Committee on Veterans Affairs to recommend an FY 2003 appropriation of at least $460 million for the VA medical and prosthetics research program. This represents growth in program dollars of $74 million (19%).

Four core needs justify the FOVA recommendation of $460 million:

1. Investments in investigator-initiated research projects at the VA have led to an explosion of knowledge that promises to advance our knowledge of disease and unlock new strategies for prevention, treatment and cures. Attachment 1 is a list of just a few of VA's recent achievements and initiatives. However, many health challenges still confront the veteran community. Additional funding is needed to take advantage of the burgeoning scientific opportunities and to improve quality of life for our nation's veterans as well as the general public. FOVA urges the Committee to support additional funding for the following research priority areas identified by the VA for FY 2003:

- Quality of Care: Additional funding for the Quality Enhancement Research Initiative (QUERI) program would be used to fund centers in prostate cancer and dementia/Alzheimer's.
- Special Populations: VA would expand research in quality of care, community access and restoration of function to achieve greater understanding of existing racial, ethnic and gender disparities in health care.

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*The Administration's budget request for a $38 million increase for VA research includes a shift from OPM to VA of $15 million in accrued government health and retirement benefit funds. Consequently, the Administration's budget proposes a $23 million (6%) increase in research program funds plus $15 million in benefit expenses previously held in an OPM account, for a total increase of $38 million (10%) over current year funding of $371 million.

• Diseases of the Brain: Additional studies are needed on the impact of different classes of psychiatric drugs on cognitive and behavioral function.
• Treatment Strategies in Chronic Progressive Multiple Sclerosis: Recent studies have shown that immunotherapy of acute MS can reduce disability. More studies are needed to determine the optimal therapy for patients.
• Micro Technology: In the area of low vision, work in retinal prostheses is an emerging science and may restore sight lost as a result of a variety of disorders including age-related macular degeneration and retinal pigmentosa.
• Patient Outcomes in Rehabilitative Care: Specific areas of emphasis include long-term care strategies to enhance patients' independence and activities of daily life, consequences of community reintegration and the impact of assistive technology on quality and functionality of life.
• Chronic Disease Management: VA is proposing two major initiatives in comparing clinical efficacy of 1) vascular surgery conducted on and off cardiopulmonary bypass machines, and 2) open versus endovascular surgery for abdominal aortic aneurysms.

2. The complexity of research combined with biomedical research inflation has increased the costs of research. The average cost of each VA research project is now $150,000, a 9% increase in just two years. As a result, VA requires an increase of at least $15 million just to maintain a stable number of programs.

3. In response to the events of September 11, VA seeks to establish a research portfolio to address the threats of bio-terrorism. This objective is consistent with VA's statutory obligation to provide medical back-up services in times of national emergencies. VA has an established history of research accomplishments in the areas of infectious diseases and immunology, including vaccine development. The laboratories of VA research scientists are disseminated nationwide, and are affiliated with top-flight universities. VA research provides a unique national resource that can be readily adapted and quickly mobilized in response to diverse biological threats.

To meet this emerging challenge, consistent with H.R. 3253, the National Medical Emergency Medical Preparedness Act of 2001, FOVA strongly supports VA's proposal to establish four new centers of research excellence focusing on fundamental issues critical for responding to chemical, biological and radiological threats to public safety. The targeted research portfolio would include pathogen detection, disease diagnosis and treatment, protection, and vaccine development. The mission of these centers would also encompass the evaluation and management of illnesses consequent to military service, especially in our current conflict.

4. VA's career development programs are a national resource for training the next generation of clinician scientists, those doctors who treat patients and address questions that have a direct impact on patient care. Additional funding is needed to expand this program in order to address the growing national shortage of clinician-investigators.

Separate from its recommendations for the VA research appropriation, FOVA strongly encourages the Committee to address the increasingly urgent need for improvements in VA's research facilities.

In 1997, NIH conducted site visits of six VA research facilities and concluded that, "VA has had increasing difficulty in providing sufficient resources via its congressional appropriation to satisfactorily fund the infrastructure necessary to support research at the VAMCs." It is FOVA's understanding that VA has made no significant, centrally administered investment in its existing research facilities since this finding. Ventilation, electrical supply and plumbing appear frequently on lists of needed upgrades along with space reconfiguration. Substandard facilities make VA a less attractive partner in research collaborations with affiliated universities; reduce VA's ability to leverage the R&D appropriation with other federal and private sector funding; and make it difficult to attract cutting edge researchers, both clinician investigators and laboratory scientists, to careers in VA. Facility R&D Committees regularly disapprove projects for funding consideration because the facility does not have the necessary infrastructure and has little prospect of acquiring it.

Under the current system, research must compete with other medical facility and clinical needs for basic infrastructure and physical plant support. Unfortunately, the minor construction appropriation is chronically inadequate to meet facility needs for clinical improvements much less research upgrades, and year after year the list of urgently needed research repairs and upgrades grows longer. VA has identified 18 sites in urgent need of minor construction funding to upgrade their research facilities. These sites plus the many facilities with smaller, but no less important needs, provide more than sufficient justification for an appropriation of $45 million specifically for research facility improvements.

FOVA recommends that a new funding mechanism, such as a minor construction appropriation specifically for research facilities, be developed to provide a permanent, steady stream of resources dedicated to upgrading and renovating existing research facilities. State-of-the-art research requires state-of-the-art facilities.

FOVA thanks the Committee for consideration of its views. For questions or additional information, please contact any member of the FOVA executive committee listed on this letterhead. Thank you for your consideration.

Organizations that have endorsed FOVA's FY 2003 recommendations (as of February 7, 2002):

Administrators of Internal Medicine; Alliance for Aging Research; Alzheimer's Association; American Academy of Child and Adolescent Psychiatry; American Academy of Neurology; American Academy of Opthalmology; American Academy of Orthopaedic Surgeons; American Association of Colleges of Osteopathic Medicine; American Association of Colleges of Pharmacy; American Association of Neurological Surgeons; American Association of Spinal Cord Injury Nurses; American Association of Spinal Cord Injury Psychologists and Social Workers; American College of Clinical Pharmacology; American College of Physicians-American Society of Internal Medicine; American College of Rheumatology; American Dental Education Association; American Federation for Medical Research; American Gastroenterological Association; American Geriatrics Society; American Gold Star Mothers of America; American Heart Association; American Lung Association; American Military Retirees Association; American Optometric Association; American Osteopathic Association; American Paraplegia Society; American Physiological Society; American Psychiatric Association; American Psychological Association; American Society for Pharmacology and Experimental Therapeutics; American Society of Hematology; American Society of Nephrology; American Thoracic Society; American War Mothers; Association for Assessment and Accreditation of Laboratory Animal Care International; Association for Research in Vision and Ophthalmology; Association of Academic Health Centers; Association of American Medical Colleges; Association of Pathology Chairs; Association of Professors of Medicine; Association of Program Directors in Internal Medicine; Association of Schools and Colleges of Optometry; Association of Subspecialty Professors; Association of VA Chiefs of Medicine; Blinded Veterans Association; Blue Star Mothers of America; Clerkship Directors in Internal Medicine; Coalition for American Trauma Care; Coalition for Heath Services Research; Congress of Neurological Surgeons; Digestive Disease National Coalition; Gerontological Society of America; Independence Technology, Inc.; Johnson & Johnson; Juvenile Diabetes Research Foundation International; Legion of Valor; Medicine-Pediatrics Program Directors Association; National Alliance for the Mentally Ill; National Association for Biomedical Research; National Association for the Advancement of Orthotics and Prosthetics; National Association for Uniformed Services; National Association of State Universities and Land Grant Colleges; National Association of VA Dermatologists; National Association of VA Physicians and Dentists; National Association of Veterans' Research and Education Foundations; National Mental Health Association; National Multiple Sclerosis Society; National Organization of Rare Disorders; Nurses Organization of Veterans Affairs; Paralyzed Veterans of America; Partnership Foundation for Optometric Education; Research Society on Alcoholism; Research!America; Society for Investigative Dermatology; Society for Neuroscience; Society of General Internal Medicine; Veterans Affairs Physician Assistant Association; Veterans of the Vietnam War.

ATTACHMENT 1.—RESEARCH—RECENT ACHIEVEMENTS AND INITIATIVES

PROMISE FOR TB VACCINE

Researchers at the Portland VA have found a unique mechanism by which human T cells recognize cells infected with Mycobacterium tuberculosis, the bacteria that cause TB. They have found that the molecule HLA–E can present TB antigens to cytotoxic T cells. A further understanding of this mechanism may facilitate the development of an improved TB vaccine. Worldwide, over 2 million people die each year from TB. Advancement towards an effective TB vaccine has significant potential to improve both national and global health.

NEW CENTERS TO STUDY PARKINSON'S DISEASE

VA created six new centers specializing in research, education and clinical care for Parkinson's disease. The centers—in Houston, Philadelphia, Portland (Ore.), Richmond (Va.), San Francisco and West Los Angeles—will conduct research covering basic biomedicine, clinical trials, rehabilitation, and health services. In addi-

tion, each center will take part in a major VA clinical trial to assess the effectiveness of surgical implantation of deep brain stimulators to reduce symptoms. (Feb. 2001)

KEY TO WASTING SYNDROME DISCOVERED

Researchers at the San Diego VA Medical Center have unraveled the biological chain of events that causes wasting syndrome in mice, and identified the same process in liver and tissue from cancer patients. Wasting syndrome or cachexia, affects about half of all cancer and HIV/AIDS patients, as well as those with bacterial and parasitic diseases, rheumatoid arthritis, and chronic diseases of the bowel, liver, lungs and heart. By noting the similarities between animal and human models, researchers hope to expedite the development of treatments to help patients. (Dec. 2001)

VA EVALUATING ROBOTIC WALKER FOR VISION-IMPAIRED

VA researchers in Pittsburgh and Atlanta are testing a new high-tech walking frame designed to promote mobility and independence for the vision-impaired frail elderly. Using laser range finders, sonar sensors, steering motors and a motion controller, the Personal Adaptive Mobility Aid (PAM-AID) seeks to build the functionality of a guide dog into a robust walking frame. (Oct. 2001)

VA ESTABLISHES NEW HIV RESEARCH CENTER

VA is the nation's largest single provider of health care to HIV-infected persons. A new Center of HIV Research Resources at the Palo Alto VA Health Care System seeks to improve health care for veterans by assessing research and clinical trials throughout VA and other agencies and determining their potential for further research and clinical application. (Oct. 2001)

REHAB RESEARCHERS COLLABORATE IN ARTIFICIAL RETINA TRIALS

VA researchers from the Rehabilitation Research and Development Service have recently collaborated with colleagues at the Louisiana State University Medical Center on studies to implant silicon-chip retinas in the eyes of patients blinded by retinal disease. About the size of a pinhead, the artificial silicon retinas are completely self-contained and require no wires or batteries. They contain 3,500 microscopic solar cells that generate electrical current in response to light. The implants stimulate healthy retinal cells underneath the retina in a pattern that resembles the light images focused on the chips. These images are then transmitted to the brain via the optic nerve. The implants are designed to treat retinitis pigmentosa and macular degeneration. (Sept. 2001)

NEW BLOOD TEST SPEEDS DIAGNOSIS OF HEART ATTACKS

Researchers at the San Diego VA Medical Center have developed a simple, inexpensive blood test to increase the speed at which heart attacks are diagnosed in hospital emergency rooms. The new blood tests can rule out a heart attack with 100% accuracy within 90 minutes by looking for three cardiac enzymes released by distressed heart tissue during an attack. Ruling out a heart attack by traditional methods usually takes 6 to 24 hours. As a result, critical care admissions dropped 40% and overall hospital admissions dropped 20%. (Sept. 2001)

CHRONIC LYMPHOCYTIC LEUKEMIA MAY BE UNDERESTIMATED

VA researchers at the Central Arkansas Veterans Healthcare System have found that the true incidence of Chronic Lymphocytic Leukemia (CLL) is substantially higher than estimated from the tumor registry database. Researchers credited the VA's Computerized Patient Record System (CPRS) as making the study possible by allowing researchers to review data from a large patient population without handling paper records. Revision in the data may show CLL to be the most common lymphoid malignancy in the United States. (Sept. 2001)

FRIENDLY VIRUS MAY SLOW REPLICATION OF HIV

VA researchers at the University of Iowa have shown that a form of the hepatitis virus called GPV–C may prolong the life of patients with HIV by preventing the HIV from replicating. GPV–C does not appear to cause any symptoms and may provide future therapy options for HIV. Specifically, the VA team showed that infecting human blood cells with GPV–C in the laboratory slowed the rate at which HIV multiplies. (Sept. 2001)

HIGHER ESTROGEN DOSES MAY ENHANCE MEMORY FOR ALZHEIMER'S PATIENTS

VA researchers have found that higher doses of estrogen may enhance memory and attention for post-menopausal women with Alzheimer's Disease. Building on previous research showing the positive effects of estrogen administered by a skin patch, the researchers showed that a short-term administration of a higher dose of estrogen was found to significantly improve verbal and visual memory as well as attention in post-menopausal women. Although estrogen therapy does not show improved brain function for patients with mild to moderate Alzheimer's, it may slow the progression or prevent the disease. (Aug. 2001)

DIET AND EXERCISE REDUCE RISK AND DELAY ONSET OF TYPE 2 DIABETES

As part of the Diabetes Prevention Program (DPP), researchers at the VA Puget Sound Health Care System and the University of Washington have collaborated in a major clinical trial that showed at least 10 million Americans can reduce their risk of contracting Type 2 diabetes with a regimen of diet and exercise. Funded by a wide group of federal agencies, private associations, pharmaceutical companies and product manufacturers, the DPP was ended a year early because the data had clearly answered the major research questions. (Aug. 2001)

VA RESEARCHER IDENTIFIES BREAST CANCER GENE

A VA researcher at the San Francisco VA Medical Center and the University of California at San Francisco led a study that showed that women who have a specific sequence of a transforming growth-factor gene have a 60% lower risk of developing breast cancer. (June 2001)

INCREASED "GOOD" CHOLESTEROL REDUCES RATE OF STROKES

A VA Cooperative Study at 20 VA Medical Centers has found that treatment aimed at raising levels of high-density lipoproteins (HDL), commonly called "good" cholesterol, substantially reduces the incidence of strokes in some patients. Patients who received the drug Gemfibrozil had a 31% lower incidence of stroke. The result is part of a larger study aimed at showing that higher HDL levels reduce the risk of major cardiovascular events. (June 2001)

BRAIN DEVELOPMENT CONTINUES INTO LATE-40'S

An inter-agency study led by a VA researcher at the Central Arkansas Veterans Healthcare System has shown that the brain continues to develop in late 40-year olds. This view contradicts the current view that brain maturation ends before age 20 and may shed light on brain ailments such as Alzheimer's Disease, schizophrenia and drug addiction. Using magnetic resonance imaging (MRI) to measure brain development, the study showed that so-called white matter—where memory, higher reasoning, and impulse functions take place—continues to develop until the age of 48, on average. (May 2001)

REDUCED OPIATE TREATMENT MAY INCREASE EFFICACY OF CHRONIC PAIN TREATMENT

Researchers at the Tampa VA Medical Center have found that patients taking opiates for chronic pain conditions reported no greater pain intensity than those not taking the drugs. Those receiving opiate treatment did report increased impairment. The program gradually phased out opiate use and those who remained off the drugs reported less pain and increased functionality and reduced depression. (May 2001)

NEW TECHNIQUE TO EVALUATE CORNEAL TISSUE FOR IMPLANTS

Researchers at the Central Arkansas Veterans Healthcare System and the Jones Eye Institute at the University of Arkansas for Medical Sciences have developed a new technique to evaluate the surface of a cornea to determine suitability for transplantation. The new technique allows for evaluation of the entire surface of the cornea; current inspection is done visually or by methods that detect only large lesions. (May 2001)

OLD DRUG RESISTS PULL OF COCAINE

Researchers at the Philadelphia VA Medical Center and the University of Pennsylvania report that Propranolol, a drug currently used to treat high blood pressure, helps addicts remain in treatment when the withdrawal effects of cocaine are especially high and treatment dropout rates are otherwise high. The research suggests

that the drug reduces withdrawal symptoms by lowering the anxiety causing effects of adrenaline. (April 2001)

NEW METHOD TO TREAT OSTEOPOROSIS, GROW BONE TISSUE

By using a synthetic form of estrogen that promotes bone growth without affecting the reproductive system, researchers at the Central Arkansas Veterans Healthcare System and the University of Arkansas for Medical Sciences may have discovered a new way to treat osteoporosis. Existing estrogen replacement therapy for osteoporosis is associated with several side effects including uterine cancer. This conceptual breakthrough could lead to a new generation of drugs and hormone therapies. (March 2001)

NATURAL RECOVERY FROM SPINAL CORD INJURY SHOWN IN RATS

Researchers at the San Diego VA Medical Center have found that rats with spinal cord injuries develop some spontaneous re-growth of nerves leading to increased motor function. In rats where 97% of the spinal cord connections are severed, rats were able to regain function within four weeks of surgery. Further research in continuing to determine how this process of "sprouting" can be enhanced. (March 2001)

FLU VACCINES COULD SAVE THE NATION $1.3 BILLION ANNUALLY

Routine influenza vaccinations of all working adults could save the nation as much as $1.3 billion each year according to a study led by researchers at the Minneapolis VA Medical Center and the University of Minnesota Medical School. By examining both the direct and indirect costs associated with influenza, researchers estimated that health care costs could be reduced by an average of $13.66 per person vaccinated. (March 2001)

IMPLANTED ELECTRODES HELP STROKE PATIENTS WALK

Using a technique known as Functional Neuromuscular Stimulation (FNS), VA scientists implanted electrodes in the leg muscles of stroke patients and used sophisticated software to electrically stimulate the muscles over a six-month course of treatment. The patients experienced significant improvements in gait and other abilities, with no adverse effects. The research was described in the Journal of Rehabilitation Research and Development and other journals. (Feb. 2001)

PREPARED STATEMENT OF RICHARD WEIDMAN, DIRECTOR OF GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA

Chairman Rockefeller, Ranking Member Specter, and other distinguished members of the committee, Vietnam Veterans of America (VVA) is grateful for this opportunity to provide testimony on the administration's fiscal year 2003 budget request for vitally needed veterans services.

I want to preface my remarks by saying that VVA continues to hold Secretary Principi in the highest regard. He has worked with us to address a number of issues of concern to VVA, its membership, and all veterans. We believe that his commitment to helping veterans is genuine. In contrast, VVA believes that some permanent members of the bureaucracy at the Office of Management and Budget (OMB) may not share his understanding or concern for veterans, particularly low-income and other economically disadvantaged veterans.

When President Bush announced in his State of the Union speech that he would seek "an historic increase" in funding for veterans health care, VVA's leaders and members were left with the impression that the President was about to make a clean break with the past, that veterans could expect full and honest funding of real appropriated dollars for real health care. Having examined the budget in some detail, we have found budget gimmicks built into the overall request, making it less of an "historic increase" than it might seem at first glance.

The President has asked for $1.414 billion more for FY2003 than the level set for FY2002, and this is a significant increase in comparison to some other programs. While the President was correct when he and the U. S. Department of Veterans Affairs (VA) stated in their press release of February 4 that the FY 2003 proposed budget was the largest overall increase in recent memory, it would in fact be the second largest increase ever provided for veterans health care in purely appropriated dollars. In ordinary times, this would be a major achievement. These are not ordinary times, however.

We believe that the Veterans Health Administration (VHA) needs at least another $1.3 billion in addition to the $1.414 that the President requested. However, that

additional $2.7 billion for veterans health care over the FY2002 level must be "real" appropriated dollars. An appropriation of this magnitude is vitally needed partly because of the significant shortfall this year, which made the starting base too low. Indeed, it is clear that a supplemental appropriation of approximately $750 million is needed to stop the reductions in force now occurring at every VA medical facility in the nation. A $2.7 billion increase in the appropriated dollars is vitally needed to advance meaningful and permanent improvements in veterans health care.

VVA would also point out that one cannot speak realistically of preparedness for further attacks from our enemies on American soil and of homeland security without ensuring that the VA healthcare system is restored enough funding and positions for the VHA to be able to rebuild the organizational capacity lost since 1996. Put quite simply, in case of an attack resulting in 5,000 or more casualties at one time in any given congressional district, the civilian medical system would be overwhelmed and the VHA medical facilities would implode. Many American citizens would suffer and die needlessly in such a scenario. Currently the VA cannot properly meet its first three missions, much less adequately meet the vital "Fourth Mission" of acting as a backup to the National Disaster Medical System.

I will spend the balance of my testimony providing specific examples that I think help illustrate this brutal reality.

"FUZZY MATH"

The VA press release touting the President's budget request claimed that it was "the largest increase ever for the Department of Veterans Affairs." As House Veterans Affairs Committee Ranking Member Lane Evans has pointed out, of the $25.5 billion the Bush administration claims the budget will provide for veterans medical care, $794 million will simply shift personnel-related costs to VA from the Office of Personnel Management (OPM). Another $1.28 billion is to offset unavoidable cost increases like inflation, higher pharmaceutical prices, and federal pay raises. It was this type of budgetary sleight-of-hand that helped produce the VA's current FY 2002 budget shortfall, which even the most conservative estimates place at $492 million. If the same accounting gimmicks are allowed to pass as "realistic" budget policy for FY 2003, we can expect even larger shortfalls by this time next year.

What is especially disturbing about the administration's rosy claims over the FY 2003 budget is their belief that they will be able to achieve significant revenue increases through the Medical Care Collection Fund (MCCF), the third-party payer billing mechanism used by the VA to recover costs for treating service-connected veterans for nonservice-connected ailments. Every year between 1995 and 2000, MCCF collections consistently fell far short of the Executive branch projections—often by hundreds of millions of dollars. VVA is highly skeptical that this trend will suddenly reverse unless fundamental management reforms are implemented that lead to genuine increases in MCCF collections.

The VA has an equally undistinguished track record of collecting from private insurers. As GAO reported in 1999, VA collections from insurers declined in every fiscal year from 1995 through 1999. From a peak of $532 million in 1995, VA third-party collections declined to roughly $400 million by the end of fiscal year 1999. While we understand that there was some slight improvement during 2001, GAO has reported that the increase was largely due to a shift from a flat rate to a "reasonable charges" billing model. The billing model change allowed the VA to do a better job of collecting reimbursements for treating roughly the same number of veterans as in FY 2001. Thus, unless other improvements in billing occur, MCCF collections are likely to level off or even decline in future years, invalidating OMB's optimistic assumptions about this revenue stream.

VVA believes that the entire concept of using co-payments and third-party collections as an integral part of the VA budget request is a fundamentally flawed accounting gimmick, in addition to putting a significant part of the burden of paying for veterans health care on the backs of the veterans themselves. OMB's penchant for "discounting" the Veterans Health Administration's budget request by the amount in collections anticipated inevitably makes the collections a wash in terms of bringing more revenue into the chronically starved veterans health care system. OMB has repeated this practice in the FY 2003 budget, with what we believe will be predictably bad results.

Additionally, VA's shift from an inpatient-based to an outpatient-based healthcare model has dramatically reduced the number of opportunities to bill insurers for medical services; outpatient treatment episodes are almost always less costly than inpatient encounters. GAO reported in September 1999 that the annual number of VA inpatient episodes dropped by more than 250,000 between 1995 and 1998, while the number of outpatient episodes climbed by nearly 7 million. One could argue that

this has made the system more "efficient," although VVA would argue that in many instances veterans should be hospitalized, but there simply is no capacity for that clinically indicated inpatient care available at that facility or in the Veterans Integrated Service Network (VISN).

VVA does not at present have figures on the numbers of outpatient encounters involving over-65 veterans. We would suggest to the committee that this is an area requiring further study and investigation, because another key problem facing the MCCF—and one completely outside of the VA's control—is the aging veteran population. An increasing number of veterans are over 65 and thus Medicare eligible. At present, however, there is no Medicare subvention program available to the VA through which the VA could bill Medicare for veteran's health care. Because the VA is not an authorized provider under any existing HMO plan, VA cannot bill those plans for services provided to veterans.

This issue is becoming more acute due to the VA's Capital Asset Realignment for Enhanced Services (CARES) process. In essence, CARES serves as a vehicle for the VA to shut down aging medical centers, shift functions and services to more modern facilities, and expand the number of community-based outpatient clinics (CBOCs) within the VA system. We have testified before the full committee on previous occasions about our growing concerns over the decline in access to VA health care for hundreds of thousands of veterans across America.

On September 17, VVA filed comments with the VA opposing their proposed CARES-driven reorganization of VISN 12 for a number of substantial reasons, including the VA's refusal to contract for medical service for veterans living in regions not within an easy drive of a VAMC or even a CBOC. Similarly, the VA's inability to bill Medicare for services compromises health care for elderly veterans by tying over-65 veterans to VAMCs that are often hours from their homes. These issues are closely linked, and require a comprehensive Congressional response.

CO-PAYMENT DEDUCTIBLES: DRACONIAN AND DISCRIMINATORY

The Administration's proposed $1,500 per year deductible for "high income" veterans (i.e., Category 7 veterans) can most charitably be described as a form of Darwinian class warfare, an attempt to force out of the VA system some of the most economically and socially disadvantaged members of the veteran community.

What constitutes a "high income veteran" by VA standards? A single veteran earning more than $24,500 per year, or a veteran with a family of four making more than $28,800 per year. Both of these figures are well below the national poverty level. That most certainly is the case in any metropolitan area in the country, whether the veteran lives in New Jersey, Illinois, or California.

Tens of thousands of veterans nationwide are living at or just slightly above the current VA Category 7 means test threshold. We can assure this committee and the American public that if the administration's proposal is adopted, tens of thousands of veterans will effectively be priced out of health care altogether. Given the decline in state health care budgets, these low-income veterans and their families will plunge straight through the remaining shreds of a very tattered social and economic safety net, perhaps to a future of homelessness and steadily declining health for themselves and their families.

We remind this committee that many veterans who begin as Category 7's move to higher categories once their claims have been approved. While they wait for their claims to be approved, these veterans are paying much more out of pocket for their medical care than would otherwise be the case. How many veterans have slipped into poverty in this way, by losing their ability to hold down a job as their health declined, all the while having to make significant co-payments as their claims sat for months or even years?

What also happens in some cases is that veterans simply do not seek any medical care until they are so sick that they cannot work at all, therefore needing much more extensive and intensive care than if they had sought the care earlier. You can be sure that if the administration's proposal is adopted, without the Congress adjusting the means test to at least conform with the Federal poverty guidelines in a given area, the number of veterans who slip into poverty will increase as they are forced to choose between paying for health care or buying food or paying rent. Then the VA healthcare facilities will treat them, but those same veterans will cost a great deal more to treat.

VVA is fully committed to the VA acting as the primary health care system for service-disabled veterans. We recognize that those veterans who wish to receive health care from the VA for nonservice-connected conditions should pay for those services, if their economic circumstances allow them to do so. Accordingly, VVA believes that the means test threshold for Category 7 veterans should be raised to not

less than $38,000 per year for single veterans, and not less than $45,000 per year for a family of four. We also believe that the deductibles should be set on a sliding scale, with veterans at the lower economic end of the scale paying no more than a $250 per year deductible. We believe that these figures are far more realistic, affordable, and fair for the average veteran and/or veteran and family.

VVA also urges this distinguished Committee to begin seriously examining the concept of making veterans health care for service-connected disabled or potentially service-related illnesses a legally mandated right, and not merely a discretionary expenditure.

VET CENTERS: COST EFFECTIVE AND VITAL

One critical VA program that received no substantive coverage in the administration announcement of the budget was the Readjustment Counseling Service Vet Centers. As this committee knows, the Vet Centers provide a nationwide system of community-based centers designed to provide counseling for psychological war trauma. VA operates 206 Vet Centers in all 50 states, Puerto Rico, the Virgin Islands, the District of Columbia, and Guam. In 2000, Vet Centers saw more than 131,000 veterans and provided more than 890,000 visits to veterans and family members, according to the VA.

Many have expressed surprise at the sheer number of persons exhibiting Post-Traumatic Stress subsequent to the attacks of last September 11. Many also seem surprised by the acuity and the persistence of both the symptoms and of the condition itself. VVA and many of the distinguished Members on this panel were not surprised. It is now time to recognize that the Vet Centers have a vital, unique, and positive role to play in the mix of services that is so needed by today's veterans, as well as those now serving in uniform when they return to civilian life.

Interdisciplinary teams that include psychologists, nurses, and social workers staff the centers. Readjustment counseling features a non-medical setting, a mix of social services, community outreach activities, psychological counseling for war-related experiences and family counseling. These services are designed to assist combat-affected veterans and other veterans have well-adjusted lives. In other words, the Vet Centers help families stay together, help veterans surmount problems that threaten their job, and help those unemployed to become more job ready. The Vet Centers are the only element of the VA that is authorized to treat family members, even when the veteran refuses to come in for treatment. This service is part of the holistic approach to health care that VVA has been advocating for many years.

VVA knows from our members and from talking to Vet Center staff across the country that the Vet Centers have been inundated with "new" veterans and their family members seeking counseling, as well as previously treated veterans and their families seeking additional counseling and assistance in the wake of the September 2001 terrorist attacks on the United States. We believe that this program needs a minimum increase of $17 million to both enhance organizational capacity and to be able to deal even more effectively with the new influx of cases related to the terrorist attacks. In addition, an additional 250 FTEE must be added. Most of the $17 million would be used to pay for a family services counselor in each of the 206 Vet Centers, and to augment those Centers with the most overwhelming needs. This is a very modest increase that will pay very large dividends in assisting veterans, and indeed whole communities by extension.

NATIONAL CENTER FOR POST-TRAUMATIC STRESS DISORDER

Related to our concerns regarding funding for the Vet Centers, VVA also believe that the National Center for Post-traumatic Stress Disorder (NCPTSD) must be expressly authorized and mandated in statute, and that NCPTSD should receive a line item funding directly in the appropriations bill of not less than $20 million each year. This is necessary in order to ensure that this invaluable national asset remains a viable research, repository, and consultation center for clinicians at VHA, FEMA, and other clinicians in the public and private sector. This national asset not only benefits combat veterans, but also many others who can benefit from its research into the effects of trauma such as the attacks on September 11 on the physical and emotional health.

MEDICAL RESEARCH

The administration has requested $409 million for the VA research budget in FY 2003, an approximately $38 million increase from FY 2002. VVA will support this request only if the committee issues report language mandating that VA approve only those research projects that are directly relevant to the specific health concerns or service-related exposures of veterans.

Moreover, new research projects should only be funded if the researchers collect the full military medical history of veteran subjects and patients involved in the study. We believe such prescriptive measures are the only way to begin changing the VA Research and Development Office's corporate culture, which currently seems to view the VA's research mission as one largely dedicated to general medical research, rather than one focused on medical research specific to and relevant for veterans. Despite continuing efforts of VVA leaders to help this section of VHA to understand the vital importance of this refocusing of their efforts, persuasion and intellectual arguments have not worked. Therefore, we ask the Congress to mandate such a proper focus.

Moreover, VVA believes that it is long past time to end the DoD-VA monopoly on the control of funds allocated for military and veteran-related medical research.

As we testified before the Health subcommittee last month, for the last decade, Congress has allowed the agency that most likely created the Gulf War illness problem (DoD), and the agency charged with paying for the problem (i.e., the VA, through health care and disability payments to sick veterans), to investigate Gulf War illnesses and their own role in responding to sick Desert Storm veterans. This is an obvious conflict of interest, one that has prolonged the suffering of veterans, destroyed their trust in the federal government, and resulted in the waste of at least $150 million over the past five years through OSAGWI, as the Defense Department has "investigated" its own response to Gulf War illnesses. It is also how the Pentagon and the Air Force have managed to squander over $180 million on Agent Orange-related Ranch Hand research that has produced less than half-a-dozen peer-reviewed scientific papers over the last 15 years.

A NATIONAL INSTITUTE FOR VETERANS HEALTH (NIVH) IS NEEDED

To end this conflict of interest and restore integrity to the process of investigating and treating veteran's medical conditions, last year VVA called for the creation of a National Institute of Veterans Health (NIVH) within the NIH. NIVH would not only eliminate the conflict-of-interest problem outlined above, it would provide a vehicle for establishing a medical research corporate culture focused on veteran health care, in contrast to the current VA medical corporate culture of "health care that happens to be for veterans."

VVA recognizes that the VA has established a reputation for providing advanced care for blinded veterans and those with severe ambulatory impairments. However, the VA has never truly developed a corporate culture focused on the diagnosis and treatment of the full range of environmental and occupational hazards that are unique to military service. This is especially true of the VA's Research and Development Office, where the overwhelming majority of VA-funded research programs are geared towards medical problems found in the general population, not those specific to the veteran patient population or those with military service. Many of the current projects could, at virtually no additional cost, be restructured to benefit veterans specifically, as well as the general population. This is not only proper for the VA's role, but it is also better science, since the impact of toxic exposures of war-related neuropsychiatric conditions may significantly affect both diagnosis and treatment modalities that are being investigated.

We urge this distinguished Committee to work with other jurisdictional elements of the Congress to establish a new section of the National Institutes of Health to be known as NIVH, with veteran advocates serving along with scientists who understand veteran health issues on the peer-review panels that make research funding decisions. VVA believes that by so doing the Congress would be creating a research institute that would be truly focused on the unique medical needs of veterans. Locating the NIVH within NIH would ensure that the full medical resources of the federal government and private sector could be marshaled in a rational, veteran-friendly environment, free of the politicizing and conflict-ridden influences that have for more than 20 years precluded effective research into the unique environmental and occupational hazards that have impacted the health of American veterans.

Additionally, this proposed NIVH must be supplemented by the creation of a Congressionally directed mandatory declassification review panel, whose purpose would be to screen (on both a historical and an ongoing basis) and declassify any operational or intelligence records for evidence of data that would have an impact on the health and welfare of American veterans. The need for such an entity—completely independent from the Pentagon and the U.S. intelligence community—is obvious.

Even today, thousands of pages of Gulf War-related records remain classified. In January 1998, the CIA admitted that its own internal review had identified over one million classified documents with potential relevance to Gulf War illnesses. Vir-

tually no documents associated with the 1960's era Shipboard Hazard and Defense (SHAD) program have been declassified, and DoD has thus far rebuffed VVA's FOIA requests that the documents be made public. Through the experience of the Kennedy Assassination Review Commission, we have learned that such specialized declassification panels work well. If we are to be certain that all data that may affect the health of American veterans is to be available for the veterans and their physicians, Congress must create such a standing declassification review panel immediately. Such a move would also help to restore trust and confidence among veterans in the federal government and its response to veteran's health issues.

NEEDED: MORE FUNDS FOR VETERANS HEALTH CARE AND GREATER ACCOUNTABILITY

Mr. Chairman, while VVA believes that an increase of at least $2.7 billion in appropriated dollars must be approved for FY2003 over the current FY2002 budget, there also must be additional steps taken towards assuring greater accountability for how these funds are used. Further, in order to stop further erosion of organizational capacity and prevent further reductions in vitally needed services at the VA, we must have a $750 million emergency supplemental appropriation immediately.

While Secretary Principi deserves high marks for his initial efforts to better track use of funds within the VA, especially within VHA, much more needs to be done. As one example, there is yet to be a full accounting of what happened to the $350 million appropriated for screening, testing, and treating hepatitis C, which Congress authorized last spring, of the 80% of veterans who do not use VA veteran health care facilities at all.

Additionally, VVA believes that the VA has a long way to go even to be able to tell who they have at each facility and what their function might be in the care of veterans. We would not tolerate this within the military. We should not tolerate it within the VA. If Secretary Principi needs more funds—in addition to those described above in order to speed his determined effort to develop and implement a viable management information system that will allow top leadership to make better and more timely decisions—then the Congress should provide said funds.

VVA believes that the VA, as well as other executive departments and entities, need additional tools to hold GS14, 15, and Senior Executive Service employees more accountable for both performance and their compliance with the law. VVA National President Tom Corey has written to the President, with copies to Secretary Principi and Director of the Office of Personnel Management, pledging VVA's full support in seeking legislation to allow elected and duly appointed officials to be able to rein in the sometimes rogue fourth branch of government—namely, the permanent most senior civil service and excepted personnel.

In the interim, VVA urges the Congress to require VA to post the criteria they will use to award bonuses at the beginning of each fiscal year in a given area. At the end of the year the amount of the dollar amount of each bonus and the specific reasons for awarding that amount to each recipient should be posted freely for public knowledge. If the size and reasons for these bonuses cannot stand the light of daylight and the sunshine, then said bonuses should not be awarded.

OTHER KEY VETERAN ISSUES

VVA is grateful to all in Congress (but particularly to the distinguished leaders and Members on this Committee) for the increases in the Montgomery GI Bill. These increases will make it possible for many more young veterans to acquire the education that will not only help them personally as a reward for a job well done in military service, but will greatly benefit our nation's economy in the future. VVA continues to believe strongly that what is called for is a GI Bill modeled on that accorded to World War II veterans, as we are currently engaged in a world wide war against terrorist. The accomplishment of this largest ever increase in the Montgomery GI Bill for educational benefits is something of which all of you can and should be very proud.

To ensure that all of the programs that can be utilized by eligible veterans for furthering their educations are sound and accredited, there must be an increase in the funding for the State Approving Authorities, which have the duty and expertise to accomplish this mission. VVA believes that these agencies need at least $18 million in appropriated dollars for FY2003, with increases for inflation in every year, as long as the use of these benefits stays at the current volume of usage.

In regard to the Veterans Employment & Training Service at the United States Department of Labor, the Congress should increase the amount requested for the overall activities of this function to approximately $252 million appropriated dollars for FY2003. No matter where this vital employment function ultimately is housed, additional funds are needed to provide incentives for placement (not "obtained em-

ployment") of special disabled veterans, disabled veterans, and veterans who are at risk. Further, the specific line item for the National Veterans Training Institute (NVTI), currently at the University of Colorado at Denver, should be funded at least at the $3 million mark. NVTI is one of the best elements of this entire operation, where excellence is not only taught but consistently practiced.

The vital role of small business, especially very small businesses and self-employment, must not be overlooked. The President has only asked for $750,000 for the SBA Office of Veterans Business Development for FY2003. VVA points out that most of the provisions of Public Law 106–50 have yet to be implemented some three and one half years after enactment. The Small Business Administration (SBA) appropriation for this function must be increased to at least $4 mission for FY 2003.

While VVA recognizes that the SBA is outside the jurisdiction of this Committee, many of the Members of this panel, as well as staff on both sides of the aisle, played a most key role in formulation and passage of this vital legislation. Proper funding is necessary to ensure that the potential of this law is realized.

VVA also notes that the Center for Veterans Enterprise (CVE), founded last year based on the recommendations of the "Principi Report," has been somewhat helpful in this area. While there is a great deal more that could and should be done by the VA to augment that which is done by the SBA and other entities (such as the National Veterans Business Development Corporation), Secretary Principi is to be congratulated for his work in developing the CVE, and rewarded with additional funds targeted to augment current efforts in this area.

Mr. Chairman, on behalf of Vietnam Veterans of America and our national leadership I thank you for this opportunity to express our views on the vital subject of the President's budget request for veterans services in FY2003.